STATE TITLE V BLOCK GRANT NARRATIVE
STATE: FL
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and certifications are on file in the state MCH program's central office. The assurances and certifications can be made available by contacting:

Bob Peck
Florida Department of Health
Bin A-13 (HSFFM)
4052 Bald Cypress Way
Tallahassee, FL 32399-1723

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Public input begins with the Healthy Start coalition local needs assessment process and service delivery plan development and implementation. Consumer experience surveys and focus groups are heavily relied on for needs assessment, plan development, and ongoing implementation, and consumers serve on the coalition boards. Headquarters MCH staff review and evaluate coalition needs assessments, service delivery plans, and implementation reports and use this information in planning MCH programs.

To facilitate public input, we will make the FY2006 application available over the Internet on our department website. Applications from previous years, and the FY2006 application when it is final, are at http://www.doh.state.fl.us/family/mch/docs/grant.html. You may also find this page by going to the Department of Health webpage at www.doh.state.fl.us. On that page, go to the subject list pull down menu and click on maternal and child health. From there, click on the documents link, and then click on the link for the MCH Block Grant Application. You can also reach the DOH website by going to www.myflorida.com and clicking on the "Find an Agency" link under the Welcome to Florida logo, and then clicking on the link for health.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Florida is the fourth most populous state in the nation, and the diversity of its population creates unique challenges. According to the 2000 U.S. Census, the population in Florida was 15,982,378 in 2000. Females accounted for 51.2 percent of the total population. Children under 18 accounted for 22.8 percent, while 17.6 percent were 65 or older. Of the total population, 78 percent described themselves as white, 14.6 percent as black, 1.7 percent Asian, and 0.3 percent American Indian or Alaskan native, with the rest being some other race or races. Florida residents also reflect diverse ethnicities, as evidenced by the 16.8 percent who identified themselves as Hispanic. Of all residents over 5 years of age, 23.1 percent speak a language other than English at home.

Since 2000, the population of Florida has continued to grow at a rate of approximately 2 percent each year. The Florida Legislature's Office of Economic and Demographic Research estimates the population in Florida reached 17,613,368 in July 2004. By 2015, Florida is expected to surpass New York, becoming the third most populous state after California and Texas.

Florida is also a temporary home to over 20 million tourists and visitors each year. This constant influx places a significant burden on the health care system. Migrant farm workers and other undocumented aliens are also populations that create significant impact on public health services and resources. According to a 2005 report by the Pew Hispanic Center, Florida is home to 850,000 illegal immigrants, following only California and Texas, and accounting for 9 percent of the total illegal immigrants in the nation.

Historically, many illegal immigrants have come to Florida seeking agricultural jobs, particularly in the citrus industry. Construction jobs and service-related jobs have recently seen tremendous increases in the use of illegal immigrants as a source of cheap labor. Following a trend in the 1990s that saw some advancement in the pay and benefit opportunities for immigrant labor, recent trends indicate pay is decreasing and services are becoming scarcer. As the number of illegal immigrants willing to work for low wages increases, business and industry have an unending source of cheap, exploitable labor.

The large illegal immigrant population can have a taxing effect on the social service system, as Illegal immigrants and their families need medical care and other services as well. Medicaid costs for just the births for this population are staggering. For example, Medicaid paid slightly more than $10.5m in 1996 for 4,556 deliveries to undocumented aliens. By 2004, that amount increased to over $65.3m for 16,281 deliveries. This does not include births to illegal immigrants for which the hospital absorbed the cost. Children born here to immigrant families are U.S. citizens. Without the same advantages of others, many of these families face generations of poverty-level existence, creating the possibility of years of public support and costs.

The geography of Florida can also create challenges in both the delivery of services and response to events or disasters. With a total area of 58,560 square miles, Florida ranks 22nd among states in total area, though 4,308 square miles are covered by water. Driving from Pensacola in the western panhandle to Key West at the southernmost point is nearly an 800 mile journey. The 1,197 miles of coastline become a target during hurricane season, and 2,276 miles of tidal shoreline are subject to concerns regarding water quality and fish and wildlife habitat degradation.

According to the 2000 U.S. Census, 33 of Florida's 67 counties are considered rural based on the statutory definition of "an area with a population density of less than 100 individuals per square mile or an area defined by the most recent United States Census as rural." In area, these 33 counties cover over 42 percent of the total land area. Portions of other counties also contain large, rural areas but are not classified as rural. Of the total population, 15.2 percent live in rural areas.

Poverty is also a major concern in Florida. According to the 2000 census, 12.5 percent of individuals and 9 percent of families are below the federal poverty level. Only 58.6 percent of the population age

16 or over is in the labor force, compared to 63.9 percent nationally, a figure that probably reflects the large number of retirees in the state. These data are also indicative of the overall economy and the abundance of service industry jobs that are typically low-paying.

Like many states, Florida is facing ever-increasing Medicaid costs. For many indigent families and the working-poor, whose jobs offer salaries below the federal poverty level and no medical benefits, Medicaid is the sole source of healthcare coverage. Yet even those who qualify may have difficulty receiving care, as the number of providers who accept Medicaid does not keep up with service needs. The governor has proposed allowing Medicaid recipients to join private HMOs. Changing the state Medicaid formulary to reduce the number of drugs covered is also under consideration to lower costs. The 2005 legislature declined to address major changes to Medicaid, but it remains an issue that may be addressed in coming sessions.

Bioterrorism has been a major issue in Florida since September 2001, and it continues to be an important priority in the Department of Health. According to a report released in December 2004 by the Trust for America's Health, Florida was tied with North Carolina as the two states best prepared to respond to bioterrorist attacks and other health emergencies. The score for Florida was nine out of a possible 10, while over two-thirds of states scored less than six out of 10. The report also notes that Florida was among six states recognized as being adequately prepared to distribute vaccines and antidotes in an emergency. Florida is also one of five states with the ability to fully respond to a chemical terrorism threat, and is among the one-third of states that have sufficient bioterrorism lab response capabilities.

With the threat of tropical depressions and hurricanes looming every summer, the Department of Health has published a Family Preparedness Guide for residents and visitors as a tool that includes items such as: a fill-in family plan for disasters and emergencies, steps for making a disaster supply kit, and facts about natural and man-made threats. The guide is posted on the department's website, and is available in English, Spanish, and Creole. Disaster preparedness was tested in 2004 when Florida was hit with four major hurricanes and a tropical depression within a two-month period.

Another major priority for the department is reducing racial disparities in health outcomes. In March 2005, the department hosted the 2005 Closing the Gap Summit, where national, state and local leaders, community-based organizations, health care professionals, and residents gathered to address this year's topic, Working Towards a Common Vision: Reducing Racial and Ethnic Health Disparities. The summit was held by the DOH Office of Equal Opportunity and Minority Health to address ways to decrease the morbidity and mortality rates in seven targeted diseases: cardiovascular, cancer, diabetes, HIV/AIDS, maternal and infant mortality, adult and child immunizations, and oral health care.

Each year since 2002, the legislature has provided funding for Racial and Ethnic Disparity: Closing the Gap projects with a primary focus of addressing racial and ethnic disparity in the seven target areas listed above. Projects receiving funding are selected through a competitive bid process. Currently funded maternal and infant mortality projects focus on issues such as: access to prenatal care, education, advocacy, and public awareness; support and education to pregnant women and parenting women in at-risk black communities; early intervention services for Hispanic and Haitian women of childbearing age; education on effects of infections on preterm labor; identification of conditions associated with poor birth outcomes in black women, and maternal health risk factors with strategies designed to increase physical activity and improve eating habits.

Racial disparities were further addressed in 2004 when Florida was one of five states chosen to participate in an Action Learning Lab on Reducing Racial and Ethnic Disparities in Perinatal Health Outcomes sponsored by the Association of Maternal and Child Health Programs. The purpose of this action lab was to help participants develop goals and implement strategies intended to reduce racial disparity through lasting systems change.

Focusing on those populations with the poorest birth outcomes is important, but we also must address

the needs of the overall population as well. Improvements in infant mortality and low birth weight rates have been difficult to accomplish for all races and ages. Activities to identify the greatest periods of risk have shown the importance of addressing and improving the health of women before they become pregnant. The department has created the Office of Women's Health Strategy to address a life course approach to care, including better preconceptional and interconceptional care, and other issues that affect women's health. In addition, Florida is one of three states receiving grant funding through the Integrating Comprehensive Women's Health into State MCH Programs initiative.

B. AGENCY CAPACITY

The State Title V agency's capacity to promote and protect the health of all mothers and children begins with Healthy Start. Healthy Start is the primary delivery system for preventive and primary care services for pregnant women, mothers and infants. Healthy Start helps pregnant women and infants obtain the health care and social support they need to reduce the risks for maternal and infant death and to promote good health and developmental outcomes. These efforts include not only assurance of access to health care, but also identification and intervention for psychosocial risks including incidence of domestic violence, substance abuse, potential child abuse, or neglect.

Healthy Start includes the Healthy Start Prenatal and Infant Coalitions, who have the legislative authority and responsibility to plan and develop improved local MCH service delivery systems. Through an allocation methodology developed at the state level, state and federal funding, including MCH block grant funding, is distributed to local Healthy Start coalitions to support infrastructure building and the provision of services to the MCH population. Healthy Start also includes universal risk screening for all pregnant women and infants, and care coordination services for eligible participants.

Other MCH projects include the Pregnancy Associated Mortality Review (PAMR) project and the Fetal and Infant Mortality Review (FIMR) project. The PAMR project is a population-based surveillance and selective state level case review process aimed at reducing the maternal mortality rate. The FIMR project is a community-based collaborative effort to establish a continuous quality improvement mechanism for communities that focuses not only on the medical aspects of prenatal and infant health care delivery systems, but also on the psychosocial, environmental and structural processes that contribute to fetal and infant deaths, and simultaneously complement the community-based nature of the Healthy Start coalitions.

Additional capacity is provided through the DOH Bureau of Epidemiology, which includes: periods of risk analysis to look at the proportional contribution of various periods to fetal and infant mortality; environmental epidemiology, addressing factors such as lead poisoning; birth defects surveillance; and the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is a continuing random survey of mothers of Florida newborns, designed to provide information about risk factors for adverse pregnancy outcomes and ill health in newborns. A cooperative agreement between the Centers for Disease Control (CDC) and the Florida Department of Health to conduct population-based surveillance of selected maternal behaviors that occur during pregnancy and early infancy, PRAMS generates data used for the planning and evaluation of prenatal health programs.

The 67 county health departments across the state provide a variety of direct services to the MCH population; however, more and more county health departments are working with community providers to ensure services are delivered, rather than providing the services themselves. These services vary throughout the state and may include pregnancy testing, HIV pretest and post-test counseling, prenatal care, family planning, immunizations, periodic health history and physical examinations, preconceptional and interconceptional education and counseling, laboratory screening tests for health indicators such as lead and anemia, developmental screening, risk assessment, provision of anticipatory guidance, accident prevention, and substance abuse prevention education.

County health departments are responsible for ensuring students have access to quality health services that assess, protect and promote their health and ability to learn. Over 2,000 health room

staff persons provide more than 18 million services to Florida's approximately 2.6 million K-12 students in 3,300 schools. The basic school health services provided to all public school students are: nursing and nutritional assessments; student health record reviews to ensure that physical exam and immunization requirements are complete, and that appropriate services are provided for any chronic or complex health conditions; first aid; medication administration; complex medical procedures; age/grade appropriate screening for vision, hearing, growth and development, and scoliosis; emergency health services for students who are injured or become acutely ill at school; health education classes; parent and staff consultations on student health issues that interfere with school participation; nursing assessment; and consultation for placement of students in exceptional education programs. Comprehensive and Full Service school health programs provide a broad range of health and social services in addition to basic school health services, in schools with high numbers of high-risk and medically-underserved children. Comprehensive school health provides significant emphasis on prevention of high risk behaviors, pregnancy prevention and support services for pregnant and parenting teens.

Coordinating and strengthening the health care system for children is also an important focus of the overall strategic plan for maternal and child health. Infant and child health issues that will be targeted include: racial disparity in infant and child health outcomes, quality improvement, asthma, SIDS, fetal and infant mortality review, lead poisoning, shaken baby syndrome, school readiness/health component, day care, and immunizations.

The Florida Department of Health Children's Medical Services (CMS) program provides children with special health care needs, from birth to 21 years of age, a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric care. The CMS statewide, integrated system of care includes a network of services that range from prevention and early intervention programs to primary and specialty care programs, including long-term care for medically complex children. CMS enrollees may receive medical and support services through 22 CMS area offices staffed by private physicians, in local private physician offices or other health care organizations, through regional programs, hospitals, referral centers and statewide specialty programs.

The CMS Network (CMSN) continues to serve as a managed care choice for Medicaid recipients who are required to choose a managed care option. Families with children who are eligible for Medicaid may choose the CMSN as their health care choice if they meet medical screening criteria. Services have been reimbursed directly by Medicaid on a fee-for-service arrangement. The Florida legislature has directed CMS to maximize federal Title XIX and XXI dollars for its salaried staff. CMS had been collecting targeted case management dollars which supported salaried staff, however, it was determined that administrative claiming was a more appropriate mechanism for the CMS Program. After several years of deliberation, random moment sampling, and cost reporting, the CMS Program obtained federal approval to draw down Title XIX dollars as a result of administrative claiming. In addition to the two CMSN insurance products (Title XIX and XXI), the program maintains the original CMS Safety Net program for children with special needs who are not eligible for either of the other programs.

CMS has adopted the six Maternal and Child Health Bureau's (MCHB) National Goals as its six Program Goals and created Performance Measures for each:

Goal #1: All children who are enrolled in CMS Programs and their families will partner in decision-making at all levels and will be satisfied with the services they receive.

Goal #2: All children who are enrolled in CMS Programs will receive coordinated, ongoing, comprehensive care within a medical home.

Goal #3: All children enrolled in CMS Programs and their families will have the resources to fund services within the guidelines of the CMS Program.

Goal #4: All children will be screened early and continuously assessed for emerging or changing special health care needs.

Goal #5: CMS Offices will identify culturally competent, comprehensive community-based service systems for all children enrolled in CMS Programs and their families.

Goal #6: Beginning at age 12, all teens and young adults with special health care needs who are enrolled in the CMS Network and their families will receive the services needed to make transitions to all aspects of adult life, including adult health care, work, and independence.

Each CMSN enrollee is eligible to receive care coordination. The care coordinator is a critical link in the development of a true medical home environment for the child and family. CMS has designed the Child Assessment and Play System (CMS CAPS), a web-based program, to administer comprehensive care coordination services to all CMSN enrollees. CMS area office staff utilizes CAPS to record patient assessments, care plans, and notes. The integration of the six National Goals into the CMS Program Goals, Performance Measures and CAPS further enhances the care coordination activities by ensuring the provision of ongoing, coordinated, culturally competent, comprehensive care, within the context of a medical home.

The CMS Pharmacy Benefits Program (PBM) provides increased pharmacy access for families of CMS enrollees. CMS contracts with MedImpact Healthcare Services to link with national, regional, and locally owned pharmacies throughout Florida to assist with the processing of prescriptions and to decrease waiting time for prescription refills, improve evening and weekend coverage, and provide a toll-free help desk to answer questions.

CMS, in coordination with Medicaid, has established 17 Children's Multidisciplinary Assessment Teams (CMAT) to provide cost containment, quality assurance, and utilization review for medically complex children receiving high cost, long-term medical services. CMAT functions through a multidisciplinary, inter-program, and inter-agency effort. Team membership includes the family and representatives from the Children's Medical Services and Early Steps Programs of the Department of Health, Child Welfare & Community Based Care of the Department of Children and Families, the Agency for Persons with Disabilities, and the Medicaid Program of the Agency for Health Care Administration. CMS has lead responsibility to facilitate this collaboration.

The CMS Behavioral Health Network works in conjunction with the Department of Children and Families to address the behavioral health needs for children age 5 to 19 who are between 101 percent and 200 percent of the Federal Poverty Level. Diagnoses covered include mood, psychiatric, or anxiety disorders; severe emotional disturbance; and substance dependence. Children who are eligible for Medicaid receive behavioral health services through Medicaid.

Florida's Medical Foster Care (MFC) Program is a coordinated effort between the Florida Medicaid Program within the Agency for Health Care Administration, CMS and the Child Welfare and Community Based Care Program within the Department of Children and Families. The program provides family-based care for medically complex children in foster care who cannot safely receive care in their own homes. For the medically complex foster child, this program is a cost-effective alternative to hospitalization, long-term, in-home, private duty nursing, or skilled nursing facility placement. The program currently serves approximately 500 children per year.

The Infants and Toddlers Early Intervention Program continues to enhance the statewide service delivery system to ensure a focus on positive outcomes for families and children served by the program. In 2004, the program received a federal grant from the Office of Special Education Programs in Washington, D.C. to implement an evaluation of the early intervention system under Part C of the Individuals with Disabilities Education Act. The grant will support the program in developing outcome statements, indicators, evaluation questions, and measurement approaches to demonstrate that the service delivery system is effective. The grant will also support development of training materials to build the capacity of staff and providers in the collection and use of outcome data for

program improvement.

Florida's Newborn Screening Program provides screening for all newborns for certain metabolic, congenital, and hereditary disorders prior to discharge from the birthing facility. In February 2005 Florida began screening using tandem mass spectrometry in the first hospital to begin the screening the disorders recommended by the American College of Medical Genetics and the Florida Genetics and Newborn Screening Advisory Council. It is anticipated that screening will be available statewide by January 2006. The primary goals of the program are: (1) to ensure all newborns born in Florida are screened and testing is processed within two weeks of birth; (2) to ensure all affected newborns receive appropriate confirmatory testing, counseling, and treatment as soon as possible; and (3) to ensure all affected newborns are placed into a system of care in a timely fashion.

The CMS Early Hearing Loss Detection and Intervention (EHDI) program has resulted in improvement towards achieving the Healthy People 2010 goals of screening by 1 month, diagnosis by 3 months and receipt of intervention services by 6 months of age. Newborn hearing screening is mandated and will be fully integrated into screening and reporting procedures for metabolic and genetic disorders as of July 1, 2005. A component specific to serving families of children with hearing loss has been established in the Part C Early Steps program with ongoing emphasis on improving the number and quality of early intervention service providers.

The CMS Genetics Program provides genetic evaluation, diagnosis, and counseling for children with or at risk for having a genetic disorder. Services provided include initial and follow-up diagnostic and evaluation; genetic counseling; lab studies required for confirmation of genetic disorders; confirmatory testing for infants with abnormal test results for PKU and galactosemia; dietary consultation for treatment of PKU or galactosemia; and educational programs for CMS staff. The genetics telemedicine project enables a pediatrician and a University of Florida geneticist to communicate via two-way interactive video technology. This project has reduced the wait for a genetic screening consultation from one year to less than two months. In FY2003-04, 1,791 CMS eligible clients received services from the Genetics Program.

The Pediatric HIV/AIDS Program provides infants and children with HIV/AIDS access to a continuum of services through a network of seven Pediatric HIV Referral Centers and 10 CMS satellite clinics. Pediatric HIV Program services include evaluation, diagnosis, care coordination, nutrition counseling, permanency planning, assistance with transportation, and other support services. As of December 31, 2004, 1,050 infants and children enrolled in the CMS Network were receiving services at a Pediatric HIV Referral Center or CMS HIV satellite clinic. The HIV Program at the University of South Florida conducts monthly pre-clinic chart reviews with CMS staff in Ft. Myers via two-way interactive video technology. This enables the HIV specialist to see more patients during the satellite clinics in Ft. Myers. A similar arrangement occurs between CMS staff in Pensacola and the HIV specialist from University of Florida prior to monthly satellite clinics.

CMSN has partnered with the Agency for Health Care Administration (AHCA) and Florida Hospices and Palliative Care to develop and implement a pediatric palliative care (PIC) program for children with life-threatening conditions and their families. The program would provide palliative care from the time of diagnosis through the course of treatment. Palliative care services include pain and symptom management; patient and family counseling; expressive therapies; and respite, nursing and personal care. In May 2004, Florida received state plan approval to provide palliative care services to eligible CMSN children enrolled in the state's Title XXI program (KidCare). On March 1, 2005, the Agency for Health Care Administration submitted a revision to the CMSN component of the 1915(b) Managed Care Waiver, allowing palliative care services to be extended to children with Medicaid who have life-threatening conditions. In the first 10 months of the program, 16 children served by Title XXI with life threatening conditions have received or are pending PIC services. When approved, the waiver will allow up to 1,000 children with Medicaid to access services.

The CMS Child Protection Team (CPT) Program is a medically directed, multidisciplinary program based on the concept that child abuse and neglect involve complex issues and require the expertise

of many professionals to protect children. CPTs supplement the assessment and protective supervision activities of the Department of Children and Families Child Welfare and Community Based Care (previously known as Family Safety and Preservation) and local Sheriffs Offices child protective staff in suspected reports of child abuse and neglect. There are 22 teams throughout the state to provide specialized assessments and services to child victims and their families. Services provided may include: medical diagnosis and evaluation, medical consultation, forensic and specialized interviews of suspected child victims, family psychosocial assessment, nursing assessment, psychological evaluation, multidisciplinary staffing, and, when required, expert court testimony. The CPTs served 19,952 clients and provided 36,784 team assessments in calendar year 2003. Real-time telemedicine capabilities are located in seven counties in the middle/north, more rural areas of the state. The CMS Telehealth Program works in conjunction with the CPTs to provide medical examinations of alleged child victims who are located in remote areas. A U.S. Department of Agriculture, Rural Utilities Services grant was awarded to CMS in 2004 to upgrade the current seven telemedicine sites and added two new remote sites. Another grant has been secured to support expansion of telemedicine services into the Florida Keys region.

The CMS Sexual Abuse Treatment Program (SATP) promotes the safety and well-being of Florida's children by providing specialized, comprehensive, multidisciplinary assessment and treatment services for children suspected of experiencing intra-familial sexual abuse. SATPs work with child protective investigators and CPTs. Community agencies, individuals, and other professionals may also make direct referrals. During FY 03-04, the SATP served 1,185 children, in addition to their siblings and families.

The CMSN works with the CMS Telehealth Program to maintain the CMS contracted program with the University of Florida's pediatric endocrinology staff that provides telehealth services for CMS enrollees with diabetes and other endocrinology diagnoses served by the Daytona Beach CMS area office. The use of two-way interactive video technology has proven to be an effective way of ensuring the availability of expert medical services to outlying rural areas.

CMS oversees the statewide Poison Information Center Network. Poison prevention and management information is provided 24 hours a day through a toll-free number. The Centers provide access to poison information, triage of the potentially poisoned patient, collection of pertinent data, professional consultation for health care providers, and professional and consumer education. During FY 03-04 the three centers received HRSA bioterrorism funds to develop systems for more rapid response to bioterrorism threats. During FY 2003-04, the Poison Information Center Network handled 176,466 calls, provided 859 critical consultations, provided 1,374 community educational programs for over 92,000 participants, and distributed over 417,500 pieces of information materials.

CMS has responsibility for the Shaken Baby Syndrome (SBS) information program. CMS maintains a SBS website through contract with the designated Prevent Child Abuse Florida agency. CMS distributes brochures on SBS to all birthing facilities in the state annually. A new brochure "Coping With Crying" will be distributed to birthing facilities in 2005. In 2003-04, over 200,000 SBS informational brochures were distributed to all birthing facilities in Florida and eight regional training sessions on SBS were presented for over 250 participants.

The basic statutory authority for MCH is Section 383.011, Florida Statutes, Administration of Maternal and Child Health Programs. The statute authorizes the Department of Health to administer and provide MCH programs, including the WIC program and prenatal care programs. This statute also designates the Department of Health to be the agency that receives the federal MCH and Preventive Health Services Block Grant funds. Other statutes related to the MCH program:
Section 409.810, F.S., establishes Florida KidCare.
Section 154.01, F.S., authorizes the Department of Health to operate primary care programs through the county health department delivery system, establishing a system of comprehensive integrated care.
Section 91.297, F.S., provides the authority for the Department of Health to implement a comprehensive family planning program.

Section 381.0056, F.S., delineates the joint responsibilities and cooperative efforts the Department of Health and the Department of Education have in implementing the school health services program.
Section 381.0057, F.S., establishes comprehensive school health services to provide health services in the schools, to promote the health of students and to reduce teenage pregnancy.
Section 381.0052 (e), F.S., the Public Health Dental Program Act, makes available dental preventive and educational services to all citizens and treatment services to indigent persons.
Section 383.014, F.S., authorizes screening and identification of all pregnant women entering into prenatal care and all infants born in Florida, for conditions associated with poor pregnancy outcomes and increased risk of infant mortality and morbidity.
Section 383.216, F.S., establishes prenatal and infant coalitions for the purpose of establishing partnerships among the private sector, the public sector, state government, local government, community alliances, and MCH providers and advocates, for coordinated community-based prenatal and infant health care.

The basic statutory authority for CSHCN and their families is Chapter 391, Florida Statutes, known as the Children's Medical Services Act. Related statutes include statutory authority and mandates pertaining to: screening of infants for metabolic and other hereditary and congenital disorders; infant hearing impairment; perinatal and neonatal services; child protection; sexual abuse treatment; developmental evaluation and intervention; hematology; oncology; poison centers; and parent support and training programs. Other statutes related to the Children's Medical Services Program:
Section 383.144, F.S., Infant Hearing Impairment Program.
Section 383.15-.21, F.S., Regional Perinatal Intensive Care Centers Program.
Section 383.215, F.S., Developmental Intervention and Parent Support and Training.
Sections 415.5055, 415.5095, F.S., Child Protection Teams.
Section 402.24 F.S., Recovery of Third Party Payments for Medical Services.
Chapter 385, F.S., Chronic Disease, Hematology/Oncology Care Centers Program.
Section 395.038, F.S., Regional Poison Control Centers.
Chapter 187, F.S., State Comprehensive Plan.
Section 409.905, F.S., Early and Periodic Screening, Diagnosis and Treatment Services.
Chapter 411, F.S., Florida Prevention, Early Assistance and Early Childhood Act.
98.282, Florida Laws, Healthy Start Act.

C. ORGANIZATIONAL STRUCTURE

The Florida Department of Health is directed by the Secretary, who is also the State Health Officer. The Secretary answers directly to the Governor. The Secretary is responsible for overall leadership and policy direction of the department. The Secretary is assisted by a Deputy Secretary for CMS, a Deputy State Health Officer, a Deputy Secretary responsible for administrative bureaus, and a Deputy Secretary for Health who also oversees the Office of Women's Health Strategy. The Deputy State Health Officer is responsible for the Division of Family Health Services.

The Florida Department of Health is responsible for the administration of programs carried out with allotments under Title V. Many of these programs fall within the auspices of the Division of Family Health Services and the Division of Children's Medical Services. The directors of these two divisions serve as the primary Title V contacts for the state, and play an important role in the Title V direction.

The Division Director of Family Health Services provides leadership, policy, and procedural directions for Family Health Services, which includes the bureaus of Family and Community Health, WIC and Nutrition Services, Public Health Dental, Chronic Disease Prevention and Health Promotion, and the Child Nutrition Program.

The Bureau of Family and Community Health is responsible for many of the Title V activities related to pregnant women, mothers, and infants; and children. The Chief of the Bureau of Family and Community Health directs the offices of Infant, Maternal, and Reproductive Health; Child and Adolescent Health; and Adult and Community Health. Programs within Adult and Community Health include the Sexual Violence Prevention Program, the Breast and Cervical Cancer Early Detection

Program, Domestic Violence, and the Strengthening Families Initiative. Programs within Child and Adolescent Health include Abstinence Education, School Health, and Osteoporosis Prevention.

Programs within Infant, Maternal, and Reproductive Health include Title V, Family Planning (Title X), Healthy Start, Pregnancy Associated Mortality Review, and Fetal and Infant Mortality Review. In July 2003, the Family Planning Program merged with the Office of Maternal and Child Health to form the Infant, Maternal, and Reproductive Health Unit. The purpose of this merger was to fully integrate women's healthcare through the preconceptional, prenatal, and interconceptional periods, to promote optimal health prior to and between pregnancies in order to help ensure positive birth outcomes.

D. OTHER MCH CAPACITY

The Title V programs are distributed among the Division of Family Health Services and the Division of CMS. As of May 2005, there were 30 central office staff in the Division of Family Health Services, Bureau of Family and Community Health, who perform duties for Title V funded programs. There are approximately 2,000 county health department staff who create the local infrastructure for Title V funded programs. The senior level management employees include: Annette Phelps, A.R.N.P., M.S.N., Division Director for Family Health Services, State Title V Director; Terrye Bradley, M.S.W., Bureau Chief, Family and Community Health; and Betsy Wood, R.N., B.S.N., M.P.H., Executive Community Health Nursing Director of Infant, Maternal and Reproductive Health. Capacity is also provided through the 31 Healthy Start coalitions covering 65 of the 67 counties in Florida. Department of Health county health departments serve as the Healthy Start coalition in the other two counties. Additional capacity is provided through partnerships with the private sector, the public sector, state government, local governments, community alliances, and maternal and child health care providers, and through linkages with state and national workgroups and associations that provide capacity building by enhancing current competencies for staff and technical assistance.

Annette Phelps has served as the Division Director for Family Health Services since 2002. Prior to that, Ms. Phelps served as the Bureau Chief for Family and Community Health, and was the Executive Community Health Nursing Director in the Office of Maternal and Child Health (now known as Infant, Maternal and Reproductive Health). Before joining the Central Office staff in 1989, Ms. Phelps worked for a number of years in county health departments.

Terrye Bradley came to the Department of Health in 2002. Ms. Bradley worked briefly in the Department of Juvenile Justice, where she was the Chief of Volunteer Services. Prior to her work with the Department of Juvenile Justice, Ms. Bradley was the Chief Operating Officer for an eight-site Community Health Center. She also worked several years as an administrator within a community-based hospice program.

Betsy Wood has served as the Executive Community Health Nursing Director of Infant, Maternal and Reproductive Health since 2002. Prior to that, Ms. Wood worked with the Division of Children's Medical Services for 17 years and the Bureau of HIV/AIDS for three years.

Additional capacity within the Office of Infant, Maternal and Reproductive Health includes the following personnel:

Carol Graham, PH.D., serves as the leader of the Data and Evaluation Team, and has worked in Family Health Services since 1994.

Laura Levine, R.N., B.S.N., serves as the leader of the Quality Improvement Team, and has worked in Family Health Services since 2003.

Mike Mason, B.S., and Marie Melton, R.N., B.S.N., serve as co-leaders of the Healthy Start contracts team, and have worked in Family Health Services since 1997.

Faye Alexander, R.N., B.S.N., serves as the leader of the Family Planning Program, and has worked

in Family Health Services since 1998.

As of May 2005, there were approximately 96 central office staff members in the Division of Children's Medical Services who perform duties for Title V funded programs. There were approximately 655 out-stationed staff members in the 22 CMS area offices located throughout the state. The senior level management employees include: Joseph Chiaro, M.D. Deputy, Secretary for CMS; Phyllis Sloyer, R.N., Ph.D., Division Director for CMS Network and Related Programs; Michael Haney, Ph.D., Division Director for CMS Prevention and Early Interventions Programs, and Vicki Posner, M.H.S.A., Chief for Children's Medical Services Network Operations Bureau.

Joseph Chiaro, M.D., was appointed as the Deputy Secretary for Children's Medical Services in January 2005. He has 25 years experience as a CMS physician provider and served eight years as the medical director for the Orlando (Region IV) CMS region. Dr. Chiaro spent 18 years in pediatric critical care medicine at the Arnold Palmer Hospital for Children and Women, and is board certified in Pediatrics and Pediatric Critical Care.

Phyllis Sloyer, R.N., Ph.D., has served as the Division Director for Children's Medical Services since 1996. Prior to that Dr. Sloyer has served in several managerial positions in Children's Medical Services since 1979. She also served as Associate Director of the National Center for Policy Coordination at the Institute for Child Health Policy from 1990 to 1993.

Vicki Posner has served as Chief for Children's Medical Services Network Operations Bureau since coming to the Department of Health in 2000. Prior to working for DOH, Ms. Posner directed clinical departments in major teaching centers and rural community hospitals for a number of years.

Susan Redmon, R.N., M.P.H., is a member of the Policy and Program Development Unit and has worked at CMS since 1997. Her duties include service as the CMS statewide youth transition champion.

E. STATE AGENCY COORDINATION

The Department of Health provides or coordinates public health services through headquarters programs, county health departments, CMS area offices, primary care associations, and tertiary care facilities. Services are often provided in collaboration with other state agencies, including: education; juvenile justice; corrections; social services; child welfare; Medicaid and SCHIP; social security; emergency medical services; and alcohol, drug abuse, and mental health. This effort focuses on health and preventive care services, the promotion of optimal health outcomes, and the monitoring of the health status of the population.

In order to present an integrated, seamless service delivery system to families of vulnerable children, the Division of Family Health Services works in close collaboration with Children's Medical Services to ensure communities have procedures for coordinating services to those eligible for both Healthy Start and the CMS Early Steps Program.

School health services are provided under the direction of the Department of Health and in cooperation with the Florida Department of Education. Comprehensive school health service projects provide health care services in schools with high incidences of underserved high-risk children, teenage pregnancy, and poor birth outcomes.

Under Title XXI and Medicaid, the MCH role in the State Children's Health Insurance Program is to ensure access to care through outreach and the eligibility application process, provide interagency coordination, and staff the KidCare Coordinating Council. CSHCN are served through the CMS Network. The Florida KidCare plan provides services to children under 200 percent of the federal poverty level from birth to age 19 through either a Medicaid managed care plan, MediPass, or through the Title XXI programs, MediKids and Florida Healthy Kids. MediKids is for children age 1 to 5.

The Department of Health works in partnership with the Department of Children and Families (DCF) and the Ounce of Prevention Fund of Florida on implementation of the Healthy Families Florida initiative. Healthy Families Florida provides a community-based approach that uses intensive home visiting and coordination with other support services to build an integrated, coordinated, and comprehensive system of support for the prevention of child abuse and neglect. The agencies work together to avoid duplication of services and to facilitate services needed by families served in either program.

In addition, the Department of Health has a letter of agreement with the Department of Children and Families that details collaboration between the two agencies to facilitate services for clients of both agencies. The letter of agreement includes interagency collaboration relating to facilitating the following health care services to DCF clients and its contracted service providers: HIV counseling, testing, and AIDS clinic services; family planning; Healthy Start; Early Intervention Program (Infants and Toddlers) services; prenatal care; immunizations; primary care/EPSDT; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); dental care; multiple handicap assistance teams; medical foster care; and other services as appropriate.

Coordination with WIC includes collaboration regarding breastfeeding initiatives, early entry into prenatal care, coordination with Healthy Start, addressing nutrition issues such as folic acid to prevent neural tube defects, and the development of general nutrition guidelines for inclusion in the Healthy Start standards. Coordination with other grant programs administered outside of the Department of Health includes working with Florida's Federal Healthy Start projects in selected counties, and other MCH-funded projects, including the Pediatric Pulmonary Project at the University of Florida, the MCH program of the College of Public Health at the University of South Florida, the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, the Florida State University Center for Prevention and Early Intervention, and CISS grants related to reproductive health and child abuse and neglect prevention.

Coordination with the Family Planning Program, which includes work on reducing teen pregnancy, reducing subsequent births to teens, preconceptional and interconceptional education and counseling, and abstinence education, has long been an integral part of our MCH efforts. This relationship was further enhanced in 2003 when the Family Planning Program (formerly housed within Women's Health) merged with the Maternal and Child Health Unit, to form the Infant, Maternal, and Reproductive Health Unit. This reorganization reflects a desire to fully integrate women's healthcare through the preconceptional, prenatal, and interconceptional periods, in order to promote optimal health prior to and between pregnancies, to help ensure positive birth outcomes.

The Department of Health and the Department of Children and Families continue coordinated efforts to prevent substance abuse during pregnancy and to reduce the impact of children affected. An IMRH staff person serves on the Florida Substance Abuse Prevention Advisory Council, Mrs. Bush's Changing Alcohol Norms Workgroup, and the IMRH unit has had the lead on the Florida Fetal Alcohol Spectrum Disorders Interagency Workgroup. The Department of Health also is a co-sponsor of the annual statewide Substance Abuse Prevention Conference. The Substance Abuse Program Office of DCF co-sponsored the IMRH unit's Partners Sharing Solutions Conference. The Department of Health works to increase the proficiency of health care providers in recognizing and getting needed treatment for women who abuse drugs during pregnancy and for substance-exposed infants, and in identifying and working toward resolution on issues impacting continuous and comprehensive prenatal and infant care for this high-risk population. One concrete example of these collaborations is Fetal Alcohol Spectrum Disorders -- Florida Resource Guide, which has been included on CSAP's FASD Center for Excellence website as a recommended resource. The guide may be seen at http://www.doh.state.fl.us/family/socialwork/pdf/fasd.pdf. The interagency accomplishments of the FASD Workgroup earned the group a Davis Productivity Award in 2004.

The Department of Health partnered with the March of Dimes Florida Chapter to distribute multivitamins containing folic acid and provide preconceptional education to underserved women of childbearing age that includes messages about the importance of folic acid. This was made possible

when the Florida Attorney General's office received money through a class action lawsuit against vitamin companies for price fixing, and subsequently awarded a grant to the Florida March of Dimes for a vitamin distribution project for at-risk women. The Florida chapter placed their Vitamin Settlement Project Coordinator within our Division of Family Health Services, enabling the coordinator to work within existing infrastructures to reach underserved populations, such as clients being served through county health departments and Florida's Healthy Start coalitions. As a result of this partnership, March of Dimes staff members, located throughout the state, are providing interconceptional training to county health department and Healthy Start staff. Additionally, the March of Dimes is working with the Department of Health to develop interconceptional health awareness materials that will promote greater awareness of health issues between pregnancies that impact maternal and infant outcomes.

Interagency coordination continues to be further enhanced by TEAM Florida. TEAM Florida was created in 1994 to address the coordination needed to implement the Family Preservation and Support Services Act. TEAM Florida members include individuals from the Department of Children and Families, the Department of Health, the Department of Education, the Department of Juvenile Justice, the Agency for Health Care Administration, the Department of Labor, and the Department of Community Affairs. Additional TEAM Florida members represent Healthy Families Florida, United Way of Florida's Success by Six, the state association for the prevention of child abuse and neglect, and Healthy Start coalitions.

In order for Florida to effectively respond to the challenges presented by Fetal Alcohol Spectrum Disorders, state agencies providing services to individuals with FASD and their families have been working together to reduce the number of children prenatally exposed to alcohol and to insure those with FASD have the resources needed for optimal outcomes. To that end, the Florida Fetal Alcohol Spectrum Disorder Interagency Action Group was established in September 2000 to improve the system of care for individuals with Fetal Alcohol Spectrum Disorder and their families. The action group is comprised of representatives from a variety of public and private disciplines including the Florida Departments of Health, Children and Families (Substance Abuse Program and Family Safety Office), Education, and Law Enforcement; Florida State University; the Governors Drug Policy Office; and families with children with FASD. This action group has been meeting quarterly since 2000 to strategically and systemically address Florida's FASD needs. During the last year the action group has made great progress addressing issues surrounding fetal alcohol spectrum disorders.

The Interagency Methamphetamine Workgroup was established in 2005 to review the issue of public environmental health concerns at clandestine methamphetamine labs (homes, apartments, motels, businesses, automobiles, etc.) and ways to reduce the impact on children involved. Agencies participating in this workgroup include the Department of Business and Professional Regulation, the Department of Environmental Protection, the Department of Children and Families, Department of Health, and law enforcement agencies.

The department works collaboratively with Florida universities to implement maternal and child health initiatives. These collaborations enable the state to access resources unique to the university setting. The Perinatal Data/Research Center, located at the University of Florida, provides a warehouse for maternal and child health data. The center stores and validates data, links related data files, publishes and analyzes data, and studies the impact of program interventions on health status outcomes. The department also serves as a site for public health, nursing, and social work interns from Florida A&M University and Florida State University.

Community health centers play an important role in Florida's health care delivery system. There are 28 community health centers in Florida and 128 clinic locations, though not every clinic provides a full-range of services. Centers are located in 35 of the 67 counties in Florida. Funded in part by the U.S. Public Health Service, they provide care in federally designated medically underserved areas. The centers offer primary health care, preventive health services, emergency medical services, transportation services, preventive dental care, and pharmaceutical services. Their patients include high-risk clients such as migrant farm workers, low birth weight infants, the elderly, homeless people,

and HIV patients. A number of Healthy Start coalitions contract with the centers for prenatal care and infant services, based on need and available resources. In some areas, the centers play an active role as members of the local Healthy Start coalition, which might include activities such as service delivery planning.

F. HEALTH SYSTEMS CAPACITY INDICATORS

HEALTH SYSTEMS CAPACITY IND. #01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -- 493.9) per 10,000 children less than five years of age.

Activities to reduce childhood asthma discharges included education and prevention efforts the county health departments and their school health programs to reduce asthma hospitalizations and re-hospitalizations of children. Many of these efforts were done in coordination with the Florida branch of the American Lung Association and its "Open Airways" educational program. During FY 2004, four hurricanes impacted Florida's indoor air quality and may have precipitated an increase in asthma episodes in children less than five years of age. Training and education improve the early identification of high-risk children and assist in establishing a medical home for children with asthma. The 2004 Regional and State Asthma Summit was held in April 2004. Participants, including the department's Division of Environmental Health, School Health Services, statewide health care agencies, medical and academic leaders, and community agencies, are focusing on asthma as a leading chronic disease in children. As an outcome of this summit, workgroups are collaborating with community partners to develop strategies to reduce hospitalizations and re-hospitalizations in children.

HEALTH SYSTEMS CAPACITY IND. #02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial or periodic screen.

Local organizations and communities initiate outreach activities to increase awareness of the availability of Medicaid coverage for eligible children, and the Florida KidCare partners ensures the public understands families may apply for and have their eligible children enrolled in Medicaid at any time. In addition, the Robert Wood Johnson Foundation Covering Kids Coalition is working to ensure that all eligible low-income children apply for Medicaid coverage through KidCare through collaboration with community, regional, and state organizations and KidCare community coalitions.

HEALTH SYSTEMS CAPACITY IND. #03: The percent of SCHIP enrollees whose age is less than one year who received at least one initial or periodic screen.

In Florida, infants whose family income is <200 percent of poverty are eligible for Medicaid, so information on all infants is included in HSCI#02.

HEALTH SYSTEMS CAPACITY IND. #04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

The department works in collaboration with Healthy Start coalitions statewide to ensure an adequate infrastructure is in place for the provision of first trimester prenatal care and continuous care for all pregnant women. The MomCare program, implemented statewide during FY2002, facilitates Medicaid coverage for prenatal care under the Sixth Omnibus Budget Reconciliation Act (SOBRA). MomCare provides prenatal care outreach, helps women access health care services, assists in follow-up of missed prenatal care appointments, and promotes coordination between prenatal care providers and supportive health related enabling services. The department is currently working on curricula for alternative models for the delivery of prenatal care in order to increase access, address social risk factors, and improve the quality of the prenatal care visit.

HEALTH SYSTEMS CAPACITY INDICATOR #05 (Medicaid and Non-Medicaid Comparison).

As expected, for all indicators on this form, the non-Medicaid population has considerably better outcome indicators than the Medicaid population. Please see form 18 for data.

HEALTH SYSTEMS CAPACITY INDICATOR #06 (Medicaid and CHIP eligibility levels):

Infants 0-1 whose family income is 185 percent of the Federal Poverty level and below are covered by Medicaid. Infants whose family income is between 186 percent and 200 percent of the federal poverty level are eligible for KidCare (Florida's SCHIP program). Children 1 to 6 whose family income is 133 percent of the Federal Poverty level or below are covered by Medicaid. Children 1 to 6 whose family income is between 134 percent and 200 percent of the federal poverty level are eligible for KidCare. Children 6 to 18 whose family income is 100 percent of the Federal Poverty level or below are covered by Medicaid. Children 6 to 18 whose family income is between 101 percent and 200 percent of the federal poverty level are eligible for KidCare. Pregnant women whose family income is 185 percent of the Federal Poverty level and below are covered by Medicaid.

HEALTH SYSTEMS CAPACITY IND. #07: The percent of EPSDT eligible children aged 6 through 9 years who have received any Medicaid dental services during the year

The number of children aged 6-9 who received any Medicaid dental services increased 1 percent in 2003 from 2002, but the overall utilization decreased due to a proportionally greater increase in the number of children enrolled (3 percent). For all children, there was a 3 percent increase; thus, the increase in the number of children receiving care in this age group appear to be only one-third that of all children.

Improving access to dental care for low-income persons below 200 percent of the federal poverty level is a priority of the department. Over the last several years, the department has funded initiatives to expand the infrastructure of county health department safety-net dental programs. Currently the capacity is increasing around 10 percent yearly. The majority of the persons served through our programs are Medicaid-enrolled children. We are currently in the process of finalizing a state oral health improvement plan for disadvantaged persons through broad-based input to facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors. A major strategy of the plan will be to address improvements in the Medicaid program to improve utilization. The state plan development has been facilitated through the HRSA MCH-B Oral Health Collaborative Systems grant.

HEALTH SYSTEMS CAPACITY IND. #08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN Program.

When a family, who meets the financial eligibility criteria for SSI, applies for benefits, the application is sent to the Office of Disability Determination Services for a medical eligibility decision. After a medical decision is made, the information about the child, whether eligible or not eligible for SSI benefits, is sent to the CMS Program Office. The CMS SSA/SSI Liaison reviews the information about the child. If the child is appropriate for CMS services, the information about the child is sent to the CMS office in the area where the child resides. An individual in the local CMS office contacts the child's family to find out if the child has a health care provider. If not, the family is invited to apply for services of CMS. When a child with mental illness applies for SSI benefits, the CMS SSA/SSI liaison sends the information about that child to the Children's Mental Health Program in the Department of Children and Families for follow-up.

FORM 19: HEALTH SYSTEMS CAPACITY INDICATOR -- REPORTING AND TRACKING FORM

Infant Death Certificates: This linkage has been accomplished and extended during the project period to include birth records linked to the following:

Fetal and infant death records Healthy Start prenatal risk screening data
Healthy Start infant risk screening data Healthy Start prenatal services
Medicaid participation WIC participation
Census Tract Information

The data has been made available to county health departments and Healthy Start coalitions for analysis of outcomes in their area.

Medicaid Eligibility or Paid Claims Files: This project is ongoing in collaboration with the Florida Agency for Health Care Administration; the Office of Planning, Evaluation, and Data Analysis; the University of South Florida Lawton and Rhea Chiles Center for Healthy Mothers and Healthy Babies; and the University of Florida's Perinatal Data Center. Activities are ongoing for the evaluation of the Florida 1915(B) Healthy Start Medicaid Waiver

WIC Eligibility Files: These files are included in the year 2001 baseline dataset.

Newborn Screening Files: Work continues to link newborn metabolic screening data with the maternal and child health matched birth file. The Florida Healthy Start infant risk screening files have been linked to services files for the current matched file as noted above.

Hospital Discharge Survey Data: Access to this data has not yet been accomplished. Linkage to this data set requires formal interagency agreement between the Florida Department of Health and the Florida Agency for Health Care Administration. Efforts to link this data are ongoing. SSDI staff has worked with the Pregnancy Associated Mortality Review (PAMR) coordinator to begin the development of a proposal to create a linked file for birth, infant, and fetal death certificates and mother's hospital discharge files.

Birth Defects Registry: SSDI staff is working with the Florida's birth defects registry in the development of activities for the expansion to a more active surveillance in selected areas throughout the state. SSDI staff continues collaborative work with Birth Defects Registry staff to develop data linking and utilization strategies. The program areas met in April to discuss collaboration with the agreement that a next step will be to explore the potential for the inclusion of a birth defects "flag" to be included on the 2002 MCH Official Matched File.

Pregnancy Risk Assessment Monitoring System (PRAMS): Access to this dataset is now available to SSDI staff. During the reporting period, SSDI staff worked in collaboration with PRAMS staff to identify new collaborative projects. These will include the development of a PRAMS section for the Title V five year needs assessment and a qualitative analysis of PRAMS narrative data for inclusion in the needs assessment.

Youth Risk Behavior Survey (YRBS): Staff continues to work in collaboration with the School Health program and Department of Education to facilitate access to state specific YRBS data.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations. Priorities and state performance measures have been established based on needs assessment activities.

B. STATE PRIORITIES

State priorities were determined through the five-year needs assessment. That process indicated a need to focus on reducing risk factors that adversely affect outcomes for the maternal and child health population. The priorities also reflect an increased focus on reducing racial disparities. Priorities were determined using both quantitative and qualitative data, as well as the recommendations of our needs assessment advisory committee. Following is a list of the 10 state priorities for Florida.

1. Improve preconceptional and interconceptional health and well-being.

2. Decrease racial disparities in maternal and child health outcomes.

3. Increase access to health care for the maternal and child health population, including children with special health care needs.

4. Decrease maternal, infant, and child morbidity.

5. Decrease maternal, infant, and child mortality.

6. Decrease risk factors associated with poor maternal and child health outcomes.

7. Decrease teen pregnancy.

8. Ensure consumer-friendly, culturally competent systems of care.

9. Increase statewide and local data and analysis capacity.

10. Increase awareness of public health preparedness issues unique to the maternal and child health population, including children with special health care needs.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	99	99	99	99	100

Annual Indicator	99.0	99.0	99.0	99.0	99.0
Numerator	201989	203742	203524	208917	216049
Denominator	204030	205800	205580	211027	218231
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	99	99	99	99

a. Last Year's Accomplishments

Florida statutes require that every newborn born in the state must be screened before one week of age. Although parents have the option of refusing the test, almost all babies are tested. It is estimated that less than one percent of parents refuse to have their newborns participate in the statewide screening program. This is a population-based service. All of the MCH population groups are served by this measure. Follow-up activities include contracts with genetic specialty centers for referral of patients with abnormal test results, and contracts with endocrine and hematology/oncology specialty centers. Specialty referral centers provide confirmatory testing and treatment to patients identified through the Florida Newborn Screening Program. Genetic counseling, follow-up and nutritional counseling activities related to treatment and dietary management are included. Educational materials are distributed to all birthing facilities regarding the five disorders that are tested in the newborn metabolic screening.

In 2003, testing identified 2,603 babies with presumptive positive screening results. After confirmatory testing, 383 were found to have one of the five disorders. Case reports from CMS Referral Centers that provide data for 2004 are not yet available.

Enabling services activities provided by the department include referral of patients with presumptive positive test results to genetic specialty centers, endocrine specialty centers, and hematology/oncology specialty centers. Specialty referral centers provide confirmatory testing and treatment to patients identified through the Florida Newborn Screening Program. Genetic counseling, follow-up and nutritional counseling activities related to treatment and dietary management are included. Educational materials are distributed to all birthing facilities regarding the five disorders that are tested in the newborn metabolic screening. The previous two activities are population-based services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Florida contracts with three genetic specialty centers for referral of patients with abnormal PKU and galactosemia test results.		**X**		
2. Florida contracts with three endocrine specialty centers for referral of patients with abnormal congenital hypothyroidism and congenital adrenal hyperplasia test results.		**X**		
3. Florida contracts with 10 hematology/oncology specialty centers for referral of patients with abnormal hemoglobinopathy test results.		**X**		
4. Specialty referral centers provide confirmatory testing and treatment to patients identified through the screening program. Genetic counseling,			**X**	

follow-up and nutritional counseling activities (treatment and dietary management) are included.				
5. Educational materials are distributed to all birthing facilities regarding the five disorders that are tested in the newborn metabolic screening.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Children's Medical Services, which administers the Newborn Screening Program in Florida, is expanding the number of disorders screened in conjunction with the Newborn Screening Laboratory in Jacksonville. Following the recommendations of the Newborn Screening Advisory Council and the March of Dimes, the Newborn Screening Program is raising the number of disorders screened to 35 starting with Florida's Regional Perinatal Intensive Care Centers. Submitting entities are responsible for forwarding the information to the newborn's primary care physician to ensure that the medical home is informed of the results. All newborns identified through the Newborn Screening Program are medically eligible for the Children's Medical Services Network Program. These are population-based services.

c. Plan for the Coming Year

It is anticipated that expansion will continue throughout the year to include expanded screening at all birthing facilities by year's end. Additionally, testing for cystic fibrosis will be included as part of the expansion. CMS will continue to contract with specialty centers for appropriate referrals; provide genetic counseling, follow-up and nutritional counseling activities; and continue distributing educational materials to all birthing facilities.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				47	49
Annual Indicator			45.4	45.4	45.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final

	2005	2006	2007	2008	2009
Annual Performance Objective	51	53	55	57	59

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Children's Medical Services (CMS) facilitated family support and contact so more families are involved in decision-making activities. The CMS mission, vision, goals, and services are available to the public on the CMS website and on printed materials and brochures. CMS families were included in developing policy, training, and in-service education, and customer satisfaction surveys to ensure the needs of their children were met. These activities took place at the CMS central office as well as in the 22 area offices throughout the state.

Satisfaction surveys for families of children who are enrolled in CMS Programs and for CMS providers were conducted through a CMS contract with the University of Florida's Institute for Child Health Policy (ICHP). The report indicated that a total of 91 percent of the families surveyed were either very satisfied or satisfied with the benefits of the CMS program that serves their child.

CMS finished testing its pilot project for the CMS 2010 Goals and Performance Measures for Children with Special Health Care Needs. Beginning in 2005, data will be collected from each CMS area office to track the six CMS Goals.

The CMS Network (CMSN) continued to contract with the Florida Institute for Family Involvement (FIFI) to ensure family-centered care. Contract deliverables ensured family-to-family support. CMS families were included in the development of policy, training, and in-service education, an enabling service activity. FIFI subcontracted the family involvement, family centered care quality assurance, and liaison responsibilities to Family Health Partners (FHPs). FHPs worked with the families of children enrolled in CMS to assist them to better understand relevant issues, needs and available resources; resolve conflict, assisted families in navigating the system of care, and worked in partnership with CMS staff and providers to ensure a family-centered environment in all CMS area offices. FIFI conducted focus groups in each of the area offices and published a quarterly newsletter to keep families involved and informed of state and national issues that were relevant to children and youth with special health care needs and their families.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family-to-family support and contact will be facilitated throughout CMS.	X			
2. CMS staff will produce and market materials that explain the CMS Mission, Vision, Goals and Services via their website, printed materials,			X	

and other forms of media and advertising.				
3. Include CMS families in developing policy, training, and in-service education.		X		
4. A statistically significant number of Satisfaction Surveys will be obtained from children, teens, and young adults enrolled in CMS Programs or their families regarding the services received through CMS or a CMS contracted provider.				X
5. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on family partnering and satisfaction with services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Data collection from all CMS area offices began in January 2005 for the six CMS Goals. The first Goal states that: "Children who are enrolled in CMS Programs and their families will be partners with CMS in decision-making at all levels and will be satisfied with the services they receive." Data collection for this infrastructure building service will consist of two performance measures and their indicators:
Measure 1: Children and their families will have a positive perception of care.
A. % Families reporting satisfaction with the quality of primary care, obtaining referrals, needed services, and coordination among providers.
B. % Title XXI families reporting satisfaction with the quality of primary care, obtaining referrals, needed services, and coordination among providers.
C. % Complaints and grievances (# complaints/#eligible clients within the quarter).
D. % Families reporting satisfaction with CMS Area Office operations and staff (# positive response surveys/# surveys completed within the quarter).
Measure 2: Children and their families are partners with CMS in decision-making.
A. % Parents who report satisfaction with their level of involvement in setting concerns/priorities about their child's care.

In June 2005, CMSN will receive satisfaction survey data results from its 2004-2005 contract with ICHP. This year, over 2,250 families of children and youth with special health care needs who are enrolled in CMS are being surveyed. This is the third year that CMS has contracted with ICHP to conduct the telephonic surveys. ICHP uses questions from the Consumer Assessment of Health Plans Survey (CAHPS), Version 3.0. Calls are made to randomly selected families whose children are served by each of the 22 CMS area offices throughout the state as well as to families of children served by the 12 contracted Primary Care Project providers, the Medical Foster Care Program, the Children's Multidisciplinary Assessment Team, and the Naples, Florida Title XXI program. This infrastructure-building activity provides CMS with data that indicates the level of family and provider satisfaction. The results from the 2004-2005 CMS Satisfaction Survey conducted by ICHP will be included with the data outcomes obtained quarterly from CMS area offices for the CMS 2010 Goals and Performance Measures for Children with Special Health Care Needs. Data analysis will enable CMS to compare results among CMS area offices as well as to state and national data.

The CMSN continues to contract with FIFI to ensure family participation and family-centered care. Family-to-family support and contact continues to be facilitated through the activities of the Family Health Partners who are assigned to each CMS area office. FIFI is planning "Critical

Partners", under the CMS contract, to bring together families of children with special health care needs, health care professionals, and other stakeholders to discuss and develop strategies and best practices.

c. Plan for the Coming Year

Data collection from each of the CMS 22 area offices for the CMS 2010 Goals and Performance Measures for Children with Special Health Care Needs began in January 2005. Over time, as these reports are analyzed, CMS will be able to better identify strengths and challenges of meeting this and other National Performance Measures. Recently implemented, the new measurement system is too new to be able to report resulting data. Using the new measurement system, CMS area offices will continue to gather data and compile reports that will identify children at risk for and with special health care needs, utilize quality of care measures, and track health expenditures and costs of services. The results will be included in next years' report.

CMS will continue to contract with the ICHP to conduct the CMS Satisfaction Surveys of the families of CMSN enrollees and their providers to evaluate issues including access to health care and satisfaction with services. This activity allows CMS to gauge and ensure a high level of satisfaction from all of its customers.

CMS will continue to contract to ensure family centered care and family-to-family support. The contract with the current provider expires June 30, 2005, and a request for proposals will be released in early April to identify a provider to continue services.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				47	49
Annual Indicator			46.8	46.8	46.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	51	53	55	57	59

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

CMS has contracted with the University of Florida (UF) to evaluate a medical home pilot project through the Primary Care Program in Jacksonville, Managed Access to Child Health, Inc. (MATCH). MATCH has established a NICHQ / Medical Home Learning Collaborative with local physicians and communities to create a Medical Home Collaborative Project. This collaborative is between three different practices in the Jacksonville area consisting of one private practice (David Weiss, MD), and two different university based practices (UNF Pediatric Primary Care at Andrew Robinson and UF Pediatric Primary Care at San Jose).

Each practice is implementing the American Academy of Pediatrics (AAP) Medical Home Model through activities such as the development of comprehensive care plans jointly between doctors, nurses and families. Practices participating in the collaborative utilize the CMS case management data system to create comprehensive care plans and each implemented a quality improvement strategic plan utilizing the nationally validated measurement tools: the Medical Home Index and the Medical Home Family Index. This scoring mechanism allows for each practice to identify specific areas of improvement and leads to the progress on the continuum of ''medical homeness.'' Each practice addresses three or more areas for improvement per month. Discussion of the quality improvement process occurs at monthly meetings that are facilitated by the MATCH program staff.

Family participation in the development of the medical home at each practice is achieved through group meetings of families at each practice. At these meetings and during patient visits to the practice, families are encouraged to share their experiences and discuss ideas for improvements. Practices also work with the local liaison from the Florida Institute for Family Involvement (FIFI). This statewide organization provides a local liaison to offer support for parents with CSHCN and to recommend local community resources to parents as well as to the members of the Medical Home Learning Collaborative.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Demonstrate the importance of a medical home to the health and well being of children with special health care needs through data collection, satisfaction surveys, and performance measures.				X
2. Support initiatives in telehealth, and other innovative delivery systems, that are built on the CMS medical home.				X
3. Identify potential or approved providers that serve CMS children with special health care needs and their families.			X	
4. Assist families to understand the uses of telehealth.		X		
5. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on family partnering and satisfaction with services.				X
6.				

7.				
8.				
9.				
10.				

b. Current Activities

CMS has appointed a nursing consultant as the statewide medical home champion. This individual works with staff statewide to assist in the development of medical home initiatives. In fall 2004, a statewide medical home workgroup was established to promote the statewide dissemination of the medical home concept among practices across the state. Members of this workgroup consist of medical directors, primary program directors, nursing directors as well as leadership staff from headquarters. This workgroup has developed specific criteria for the development, review and implementation of medical home proposals and projects across the state.

As of January 2005, all 22 CMS area offices are utilizing the performance indicators and measures to evaluate our progress toward the medical home goal. All children who are enrolled in CMS Programs will receive ongoing, coordinated, culturally competent, comprehensive care, within the context of a medical home.

The five CMS goals and performance measures related to medical home are:

1. All children will have a primary care physician.
2. All children will be offered care coordination.
3. A care plan will be established, implemented, and reviewed for all children who choose care coordination in the CMSN.
4. All children will receive education regarding well child check-ups in accordance with the AAP Guidelines.
5. All children will receive immunizations in accordance with the AAP Guidelines.

A statewide Medical Home Summit is planned for May 2005 to offer CMS Medical and Nursing Directors the opportunity to learn more about the medical home concept and provide direction on implementation on the local level. The statewide medical home workgroup will provide technical assistance to practices across the state.

Florida was recently chosen by MCHB as one of six leadership states to promote the dissemination of medical home initiatives statewide. The six leadership states were chosen based on many factors, including the strong relationship of state Title V agency with the state and local chapters of the AAP as well as strong statewide infrastructure promoting family-centered care. In addition, annual CMS Area Office Quality Improvement reviews will continue to monitor for documentation of a medical home for each CMSN enrollee.

c. Plan for the Coming Year

Data collection from each of the CMS 22 area offices for the CMS 2010 Goals and Performance Measures for Children with Special Health Care Needs began in January 2005. Over time, as these reports are analyzed, CMS will be able to better identify strengths and challenges of meeting this and other national performance measures. Recently implemented, the new measurement system is too new to be able to report resulting data. Using the new measurement system, CMS area offices will continue to gather data and compile reports that will identify children at risk for and with special health care needs, utilize quality of care measures, and track health expenditures and costs of services. The results will be included in next years' report.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				47	49
Annual Indicator			54.4	54.4	54.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	57	59	60	61

Notes - 2002

The 2002 indicator is based on the state estimates from SLAITS. Objectives for 2003-2004 are lower that the current indicator. Program staff is not confident that reported indicator is accurate on this measure, and will modify objectives as necessary as more data is available.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Six Children's Medical Services area offices piloted the performance indicators and measures developed during the previous year for evaluation of the CMS 2010 Goals and Performance Measures for Children with Special Health Care Needs. The performance indicators and measures were evaluated by the third quarter of 2004. Results of the pilot were used to finalize the performance indicators, measures, and data collected so that the system could be launched statewide during 2005.

The electronic Child Assessment Plan System (CAPS) was piloted as well and, beginning in 2005, data collected each quarter will be analyzed for enabling services for the health related needs and planning activities that take place for each CMS enrollee.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			

	DHC	ES	PBS	IB
1. Collaborate and coordinate with Medicaid and KidCare offices to strengthen outreach and enrollment strategies.		X		
2. Identify children at risk for and with special health care needs.		X		
3. Utilize quality of care measures for children enrolled in CMS Programs.				X
4. Track health expenditures and costs of services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The third CMS goal states "Children enrolled in CMS Programs and their families will have the resources to obtain services within the guidelines of the CMS Program." As a result of the activities conducted last year with regard to performance indicators and measures that were developed and piloted, the following performance measures and indicators were identified:
Measure #1: All children are identified and enrolled in the appropriate benefit program for which they are eligible.
A. % Children who do not have their financial eligibility determined at least annually (# Safety net clients redetermined/# Safety Net clients due for redetermination within the quarter).
B. % Children without creditable health insurance who have applied for other benefit programs.
Measure #2: All CMS financial management guidelines will be followed.
A. CMS Area Offices will stay within their allocated budgets.
B. 90% Services are paid for from the appropriate funding source (Title XXI, Title XIX, and PCS for Safety Net)
Measure #3: All CMS offices will document unmet need due to lack of resources.
A. Number of Safety Net clients and estimated annual cost of care uncovered by another payer.

c. Plan for the Coming Year

Recently implemented, the new measurement system is too new to be able to report resulting data. Using the new measurement system, CMS Area Offices will continue to gather data and compile reports that will identify children at risk for and with special health care needs, utilize quality of care measures, and track health expenditures and costs of services. The results will be included in next years' report.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective				67	69
Annual Indicator			69.4	69.4	69.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	71	73	75	77	79

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. Objectives for 2003-2004 are lower that the current indicator. Program staff is not confident that reported indicator is accurate on this measure, and will modify objectives as necessary as more data is available.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Last year CMS implemented a data system to track the CMS 2010 Goals and Performance Measures for Children with Special Health Care Needs. These six goals incorporate the six key systems outcomes of the Maternal and Child Health Bureau, Division of Services for Children with Special Health Needs. A CMS pilot project was initiated in 2004 to enhance infrastructure building activities for CMS enrollees and their families through the implementation of performance measures and indicators. All of the ongoing activities for this national performance measure are conducted to increase the number of CMS programs that support all caregivers and partners; supporting children, teens, and young adults, and family leadership programs that identify families as leaders and potential leaders; promoting the use of telemedicine; and supporting family organizations and initiatives as they engage families of children at risk for and with special health care needs in effective partnerships. These activities provide direct health care, enabling, population-based, and infrastructure building services. The primary population served is children with special health care needs and their families.

Survey data was also provided, under contract, from the University of Florida's Institute for Child Health Policy (ICHP). ICHP conducts random annual Satisfaction Surveys from families of CMS enrollees. The survey questions are taken from the Consumer Assessment of Health Plans Survey (CAHPS), Version 3.0.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish and maintain CMS Programs that support all caregivers and				

partners.				X
2. Support children, teens, and young adults, and family leadership programs that identify families as leaders and potential leaders.			X	
3. Promote use of telemedicine.		X		
4. Support family organizations/initiatives as they engage families of children at risk for and with special health care needs in effective partnerships.			X	
5. Evaluate the potential benefit of telehealth and telemedicine services for CMS enrollees and their families.	X			
6. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on community-based service systems.				X
7. Provision of a Pharmacy Benefits Program to CMS enrollees.	X			
8.				
9.				
10.				

b. Current Activities

The fifth CMS goal states that "CMS Offices will identify culturally competent, comprehensive community-based service systems for all children enrolled in CMS Programs and their families." It has two performance measures and indicators. They are:
Measure 1: Each child enrolled in CMSN will have access to comprehensive, community-based service systems.
A. Area Office has developed and implemented a plan that identified recruitment, retention, and communication with physician and non-physician providers.
B. % of Clinic no-show (# of clients seen/# of clients scheduled)
C. # of Children in applicant status greater than 90 days.
D. % Parents who report that they are able to access comprehensive services for their child and family.
E. % Parents who have specialty care available in their region of the state for their child and family.
Measure 2: Decrease the amount of time required for approval of CMS physicians.
A. % CMS Physician Provider applications that are processed in less than 120 days from date of receipt.

The CMSN continues to contract with the Florida Institute for Family Involvement (FIFI) to provide family-centered care and family involvement. FIFI subcontracts with family health partners (FHPs) who are parents or caregivers of children with special health care needs whose child has been or is currently being served by a CMS area office. The FHPs are an important source of information, resources, and contact for other families of children with special health care needs.

CMS continues to contract with the University of Florida's Florida Initiative for Telemedicine and Education (FITE) Diabetes Project to provide access via telemedicine for children and youth with diabetes who are enrolled in the Daytona Beach CMS office with a University of Florida endocrinologist and staff. The data from the FITE program continue to document enhanced diabetes control for the CMSN enrollees who are served by it.

Other telehealth initiatives include the Ft. Lauderdale CMS Area Office's provision of nutritional counseling for CMS enrollees in Ft. Pierce and the Pensacola CMS Area Office, which has linked with a geneticist in Gainesville for consultation. The application of this technology to direct health care services is still relatively new for the CMS Network and there are many issues to address in the development of a telemedicine delivery system.

The results from the 2004-2005 CMS Satisfaction Survey conducted by the University of Florida's Institute for Child Health Policy (ICHP) will be included with the data outcomes obtained quarterly in 2005 from CMS area offices for the CMS 2010 Goals and Performance Measures for Children with Special Health Care Needs. Data analysis will enable CMS to compare results among CMS area offices as well as to national data.

c. Plan for the Coming Year

The data that is collected for the CMS Goals will enable CMS to measure and analyze success on a community, regional, and statewide basis as well as in comparison with national data. Recently implemented, the new measurement system is too new to be able to report resulting data. Using the new measurement system, Children's Medical Services Area Offices will continue to gather data and compile reports that will identify children at risk for and with special health care needs, utilize quality of care measures, and track health expenditures and costs of services. The results will be included in next years' report.

CMS will continue to discuss opportunities for partnerships with the University of Florida and with University of South Florida to provide telehealth services to children with special health care needs and their families. Access to services, especially for subspecialties, is a challenge for many areas of Florida. It is anticipated that these partnerships will continue to be developed so that services for children with special health care needs are available in their community whether they are provided in person or via two-way interactive audio and video technology.

CMS will be releasing a Request for Proposals to contract with a provider, beginning in July 2005, to ensure that family-centered care is the basis for services CMS provides to all children who are enrolled and their families.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective					
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8	10	12	14	16

Notes - 2002

Because only one of the states (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its state value noted. Florida will set future objectives when the actual indicator is known.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Planning for the eventual transition of all teens and young adults with special health care needs to adult services, and coordinating and facilitating transition activities with each teen, were examples of enabling services provided to increase the percentage of teens ready to transition to adulthood. CMS continued to maintain a Transition Guide on the CMS Internet, a population-based service, and participated in collaborative partnerships with community organizations and state agencies to support the federal New Freedom Initiative and the Healthy and Ready to Work Transition services and systems, an infrastructure-based service. The primary population served is adolescents and young adults with special health care needs.

CMSN care coordinators requested continuing education in-services to better inform them about the process for youth health care transition. In FY2003-2004, CMS contracted with the University of Florida's Institute for Child Health Policy (ICHP) to develop youth transition training materials to assist CMS staff in learning about the many issues and challenges youth face as they transition from pediatric-oriented to adult-oriented health care services. Those web-based educational continuing education in-services were delayed in their production and are in the process of completion. The initial response from CMS Care Coordinators who have reviewed the training was very positive. It is anticipated that the application of these training materials will continue to provide future infrastructure building services to enable CMS area office care coordinators to better serve this population.

CMS partnered with the Florida Institute for Family Involvement (FIFI) to write a successful grant application from the Utah State University's Champions for Progress Center. The grant allowed CMS to form a youth advisory board so that CMS enrollees between the ages of 12 to 21 have a voice in CMS policies, procedures, and protocols, as well as to identify youth leaders who have special health care needs. Applications from CMS enrollees between the ages of 12 to 21 were reviewed and five individuals were chosen. Communication included one face-to-face meeting, telephone conference calls, e-mails, and letters. The group chose the name Vocal Spectrum: CMS Young Adult Advisory Board. Their mission statement is "To provide information and support for those receiving CMS health care to assist in the transition to adult healthcare and life." They assist CMS in the development of materials for young adults with consideration for language and format.

A CMS Network representative attended meetings of local and state workgroups, consisting of young adults, state agency professionals (including Exceptional Student Education and Vocational Rehabilitation) and other stakeholders who met to discuss youth transition issues and challenges.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Plan for the eventual transition of all teens and young adults with special health care needs to adult services.		X		
2. CMS Network Care Coordinators will coordinate and facilitate transition activities with each teen beginning at age 12, to meet their needs.		X		
3. Create and maintain a Transition Guide on the CMS Internet.				X
4. Participate in a collaborative partnership with community organizations and state agencies to support the New Freedom Initiative and the Healthy and Ready to Work Transition services and systems.			X	
5. Create and maintain a CMS Youth Advisory Board staffed by CMS enrollees who are between 12 to 21 years of age.				X
6. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on youth transition.				X
7.				
8.				
9.				
10.				

b. Current Activities

CMS Network Care Coordinators continue to coordinate and facilitate transition activities, an enabling service. CMS anticipates the ability to track the successful completion of transition activities for each enrollee through the electronic Child Assessment Plan System (CAPS) beginning the first quarter of calendar year 2005. The sixth CMS Goal states that "Beginning at age 12, all teens and young adults with special health care needs who are enrolled in the CMS Network and their families will receive the services needed to make transitions to all aspects of adult life, including adult healthcare, work, and independence." The measures and indicators for this goal are:
Measure 1: Teens and young adults will participate in the development and periodic review of their care coordination and transition plans
A. % Youth, 12 and older, who have received transition education (# 12-18 y.o. with transition education/ # 12-18 y.o. redetermined or closed within the quarter)
Measure 2: Teens and young adults will receive transition services that are age appropriate
A. % Youth age 16 and older whose regular source of primary medical care facilitates the transition from pediatric to adult providers (# 16-21 y.o. with transition services/ #16-21 y.o. redetermined or closed within the quarter)

CMS maintains the Youth Transition section on the CMS Internet, an infrastructure building service. CMS continues to participate in collaborative partnerships with community organizations and state agencies. A CMS care coordinator from each of the 20 area offices was sponsored by the Florida Developmental Disabilities Council to attend the statewide Partners in Transition Summit in January 2005. The summit brought together youth and young adults, state agency staff, and other stakeholders from Florida communities to focus on transition strategies for their locale. It was the first time that health was a partner for many of these community groups.

The Vocal Spectrum: CMS Young Adult Advisory Board is an infrastructure building service that provides an opportunity for youth and young adults who are served by CMS to become involved in the direct health care services, enabling services and population based services that CMS provides to them. Currently, the board members are reviewing transition information that FIFI developed.

CMS is contracting with ICHP to conduct research on the health care transition of young adults

who are served by or have left the CMSN. This will result in the development of training materials for CMS staff and providers to assist them in better understanding the issues and challenges of youth with special health care needs who will be transitioning and young adults who have transitioned from pediatric-oriented to adult-oriented health care services.

c. Plan for the Coming Year

The Vocal Spectrum: CMS Young Adult Advisory Board will continue to provide CMS with ideas for the development of youth transition materials, policies, protocols, and procedures related to this goal as well as leadership opportunities for youth and young adults who are enrolled in CMS. The continuation of the Advisory Board will be included in future CMS contracts for family-centered care.

CMS will continue to partner with Florida state agencies, including: the Department of Education, Exceptional Student Education and Vocational Rehabilitation; the Agency for Persons with Disabilities; the Department of Children and Families, Mental Health; and other Florida stakeholders, including the Florida Developmental Disabilities Council, ICHP, the University of Miami Mailman Center for Child Development, and the University of South Florida's School of Medicine to ensure that health is included in every agenda that is developed for youth transition.

CMS plans to renew its contract with ICHP to continue developing youth and young adult transition educational and resource materials for CMS staff and CMS enrollees and their families as well as to research the progress and challenges that youth and young adults encounter as they transition from pediatric-based to adult-based health care.

Recently implemented, the new measurement system is too new to be able to report resulting data. Using the new measurement system, Children's Medical Services Area Offices will continue to gather data and compile reports that will identify children at risk for and with special health care needs, utilize quality of care measures, and track health expenditures and costs of services. The results will be included in next years' report.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	90	90	90
Annual Indicator	86.6	85.5	85.3	79.4	85.3
Numerator	169358	168403	174038	163405	177986
Denominator	195564	196963	204030	205800	208659
Is the Data Provisional or Final?				Final	Final

	2005	2006	2007	2008	2009
Annual Performance Objective	90	90	90	90	90

a. Last Year's Accomplishments

The following initiatives were designed to improve immunization coverage levels in 2-year-old children: the department's missed immunization opportunities policy; outreach clinics; linkages with WIC and CMS; community partnerships and immunization coalitions; coordination with Healthy Start and managed care organizations; promotion of the Standards for Pediatric Immunization Practices in the private sector; measurement of immunization coverage levels in public and private site reviews; outreach and increased enrollment in Medicaid and SCHIP; and continued implementation of the Vaccines for Children Program. Activities performed that impact this measure generally fall within the category of population-based services, offering disease prevention interventions to the entire population. Changes in immunization rates of 2-year-old children can be attributed to the following: immunization registry not fully implemented for access with private health care providers; and the partnership with WIC not fully implemented for 2003/04.

During FY2004, 85.3 percent of 2-year-olds received four diphtheria, tetanus, pertussis; three polio; and one measles, mumps, rubella immunizations. The immunization registry is functional in all 67 county health departments and includes over 1000 private health care provider practices. In addition, the activities listed above were conducted during FY2004 in an effort to increase the immunization level for young children.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Recommend all health care providers implement the Standards for Pediatric Immunization Practices.				X
2. Continue implementation of the registry (Florida Shots) in the private sector.				X
3. Implement/Continue missed opportunities policy for public and private health care providers.			X	
4. Continue WIC/Immunization linkage.		X		
5. Statewide initiative to improve collaboration with public and private stakeholders/partners in order to increase immunization coverage levels in this target population.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY2005, our plan to meet the goal of 90 percent of all 2-year-old children who are appropriately immunized includes: parent education activities; involvement of Healthy Start, immunization coalitions, and community partnerships; linkage with WIC, CMS and managed care organizations; identification of pockets of need for under-immunization; tracking

immunizations in the health department; implementation of recall systems; public and private provider site reviews that include an assessment of coverage levels and promotion of the Standards of Pediatric Immunization Practices; implementation of the immunization registry in both the public and private sector; continued implementation of the Vaccines for Children Program; and a statewide initiative to improve collaboration with stakeholders/partners in order to increase coverage levels in this target population.

We are continuing an increased emphasis with all immunization stakeholders, including Kiwanis support, through an initiative called "85 by 05" with an ultimate goal of 90 percent immunization coverage by 2010. County health departments have developed countywide immunization plans to raise the immunization rate in their area. They have reenergized their immunization programs, and are working with WIC, local medical societies, CMS, and others to develop then implement their plans.

c. Plan for the Coming Year

Our objective for FY2006 is that 90 percent of 2-year-olds receive age-appropriate immunizations. The department will continue to implement the missed immunization opportunities policy in county health departments, to ensure young children receive immunizations in a timely manner. Outreach, promotion, and surveillance of rates will be utilized to support efforts in the private sector. The department will continue to coordinate with Healthy Start coalitions to increase parent education about the importance of childhood immunizations and encourage local community partnerships. We will continue to recommend that all health care providers implement the Standards for Pediatric Immunization Practices, and continue implementation of the registry (Florida Shots) in the private sector (infrastructure-building activities). The department will continue an active partnership with the Kiwanis. We will continue to implement the missed opportunities policy for public and private health care providers (population-based) and continue the WIC and CMS/Immunization linkage (enabling). We will continue to implement the statewide initiative to improve collaboration with stakeholders/partners in order to increase coverage levels in this target population.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	33.2	32.7	32.1	23.2	23
Annual Indicator	28.8	26.0	23.6	22.4	22.2
Numerator	8645	8013	7428	7171	7381
Denominator	300216	308301	315039	320440	332828
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	22	21.5	21	20.5	20

a. Last Year's Accomplishments

During FY2004, the provisional birth rate for teens 15-17 was 22.1 per 1,000. The provisional data is lower than the annual performance objective of 23.0. Family planning, abstinence-only education, and comprehensive school health service projects share the responsibility of providing reproductive health care services to teens throughout the state. Family planning provided an array of services to teenagers beginning with preconceptional risk assessment, contraception, screening for sexually transmitted disease, and pregnancy testing. The program served 27,842 teens age 15 through 17 last year.

An important initiative to curtail teenage births was the creation of special educational activities that highlighted the role of sexual abuse and coercive sexual practices by men, particularly older men. County health department's family planning units provide services that address the responsibility of males in teenage pregnancy while educating males about sexual abuse.

The abstinence-only education program currently funds 22 public and private projects that provide services to youth age 9-18, their parents, and community members. Local projects served 11,156 teenagers 15-17 during FY2004. Abstinence-only education services are provided through in-school and out-of-school programs. Projects reinforce the abstinence message through counseling, peer mentoring, home visits, rallies, and other activities. Every project incorporates a plan for identifying and referring sexually abused youth and victims of domestic violence.

Along with services, the abstinence-only education program provides a statewide media campaign entitled It's Great to Wait. The center of the campaign is the annual It's Great to Wait regional conferences, which use a strategy that encourages participants to recognize abstinence until marriage as the healthiest choice for teens. Another important component is an abstinence-only education website, www.greattowait.com.

During the 2003/2004 school year, 46 of the 67 county health departments operated Comprehensive School Health Services Projects (CSHSP) in 342 schools, while serving 258,012 students in 342 high-risk communities with high teen birth rates. CSHSPs are designed to reduce predisposing risk factors associated with school failure, teen births, welfare dependency, violence, crime, and other health and psychosocial problems. These projects provided 2,236 pregnancy prevention classes and interventions to 39,345 student participants, and aftercare services to parenting students that enabled 76 percent of them to return to school after giving birth.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Teen pregnancy prevention classes, and case management and aftercare for students who give birth in Comprehensive School Health Services Projects.		X		
2. Conducting abstinence-only education classes.		X		
3. Conducting statewide abstinence media campaign.			X	
4. Developing community and Department of Health program collaboration.				X
5. Promoting consumer involvement.		X		

6. Provision of confidential family planning counseling and education.	X			
7. Provision of confidential family planning comprehensive contraceptive services.	X			
8.				
9.				
10.				

b. Current Activities

Preventing teen births is a critical component of the Department of Health's mission of promoting health and preventing disease. Although the department incorporates a continuum of services that address reproductive health care for youth, there is no single approach to preventing teen births that is appropriate for every youth.

Comprehensive family planning services are available in all 67 counties through county health departments and local contract providers. Priority is placed on serving low-income individuals who are at risk of unintended pregnancy. Clients are charged on a sliding-fee scale, based on their income and family size. There is no charge to clients with incomes up to 100 percent of the poverty level.

In addition to providing an array of family planning services, the department is collaborating with the Agency for Health Care Administration in revising the Medicaid Family Planning waiver program. The waiver program is designed to reduce infant mortality, unintended pregnancies, and repeat births to teens 15 to 19 by increasing the utilization of family planning services following a pregnancy.

Along with providing abstinence education activities, 22 abstinence projects encourage parental participation as an important part of service delivery. To further this effort, the It's Great To Wait regional conferences have been redesigned to include a parent component that teaches parents how to communicate with youth about abstinence.

During FY2004, CSHSPs continue to operate in 46 counties, providing pregnancy prevention classes, case management, and aftercare services that enable parenting youth to return to school and graduate. These projects are continuing to coordinate activities with local county health departments abstinence programs, school district health educators, county health department Healthy Start programs, Healthy Families Florida home visitors, school district teenage parent programs, and case managers from the Florida Department of Children and Families. Coordination of pregnancy prevention services among all programs involved in the provision of services to youth continues to be a focus within the Florida Department of Health.

c. Plan for the Coming Year

Family planning, abstinence education, and school health programs are critical components of the Florida Department of Health's plan to reduce the birth rate for teenagers 15 through 17 in FY2006. County health departments will continue to develop and improve pregnancy prevention strategies for teens through the quality improvement process. County health departments, local contract providers, Healthy Start programs, Healthy Families Florida programs, and other agencies that provide maternal and infant care services will inform postpartum women about the extended family planning services. These providers will have access to applications and client information brochures to distribute to youth to increase awareness and use of family planning services under the special Medicaid program. We anticipate there will be a reduction in the number of subsequent births to teens who access and utilize family planning services. If for some reason, the youth is not eligible to participate in the waiver program, family planning services can be provided under the Title X program.

Abstinence education will continue to focus on the management of locally funded projects in providing abstinence-only education. The marketing media campaign, which will be greatly enhanced and expanded in the coming year, will target the main population centers throughout the state. The campaign will be supported this year with a marketing media campaign evaluation. The regional conferences will bring nationally renowned abstinence speakers to several regions across the state. In addition, the program will offer a series of abstinence educator training workshops to expand the number of persons in the state trained to teach abstinence-only curricula.

For FY2006, the CSHSPs will continue to provide pregnancy prevention classes, case management, and aftercare services that enable parenting students to return to school and graduate. These projects will continue to coordinate activities with local county health department abstinence programs, school district educators, county health department Health Start programs, Health Families Florida home visitors, school district teen parent programs, and case managers fro the Department of Children and Family Services. Local county health departments will continue activities to facilitate access to services for youth, and continue to collaborate with other community agencies in dealing with teen pregnancy prevention in their communities. Programs within the department that serve youth will continue to develop strategies to reduce the rate of births to teens. The goal of these activities will be to enable teenagers to develop to their fullest potential and establish productive lives.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	42	45	25	25.2	25.4
Annual Indicator	29.5	21.7	20.7	27.0	
Numerator	18545	14833	14745	19407	
Denominator	62867	68353	71205	71823	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25.6	25.8	26	26.2	26.4

Notes - 2002

Data for 2002 are not yet available. Sealant indicator data are derived from an ad hoc report from Medicaid. The report should be available sometime in July, and we would calculate indicator data from that, probably by late July.

Notes - 2003

Data for 2003 are not yet available. Sealant indicator data are derived from an ad hoc report

from Medicaid. The report should be available sometime in July, and we would calculate indicator data from that, probably by late July.

Notes - 2004

Data for 2004 are not available.

a. Last Year's Accomplishments

The number of children receiving sealants in county health departments increased 16 percent from FY2003, reaching over 28,500 children in FY2004.

Presently, Medicaid data for this national indicator are not available. Until survey capabilities are developed, an estimate of the number of Medicaid-enrolled 8-year-olds that receive sealants on their permanent first molars is monitored as well as the number of children that receive sealants through county health department safety net programs. Medicaid estimates indicate a decreasing trend in the percent of Medicaid 8-year-olds that are receiving sealants on their permanent first molars. This decreasing trend is partially a result of county health departments and community health centers using cost-based reimbursement to bill Medicaid; thus, sealant procedures are not reported to Medicaid.

Using an estimate of the number of Medicaid patients to whom county health departments and community health centers provide sealants, it is estimated that 27 percent to 36.1 percent of Medicaid eight-year olds receive sealants.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote the development of school-based sealant programs.				X
2. Promote increased sealant utilization in county health department safety net programs.	X			
3. Develop and maintain sealant promotional material on Internet site.			X	
4. Promote the development of a surveillance system for sealant utilization on permanent molars of third and ninth graders.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Public Health Dental Program continues to promote the development of school-based sealant programs and the early placement of sealants on permanent first and second molars in county health department programs. Links to sites to order sealant promotional material are available on the program's Internet site. A strategy contained in the state oral health improvement plan, which is currently under development, relates to increasing the number of children receiving sealants. It is anticipated that the increased collaboration and partnerships resulting from the state oral health plan, which is facilitated by a HRSA State Oral Health Collaborative Systems grant, will enhance activities to assure more children receive sealants. The 2004 Legislature added oral health as one of seven priority areas to address racial and ethnic disparities through the state. Three of these Closing the Gap grants were awarded to

dental projects. One of the main focus areas of all three grants is to increase sealant utilization. Legislative budget requests are submitted annually to establish a statewide sealant program for third and seventh graders, and a regional-based surveillance system using the Association of State and Territorial Dental Directors' Basic Screening Survey Model.

c. Plan for the Coming Year

The program will continue to promote the development of school-based sealant programs through the departmental quality improvement process and coordination with school systems. HRSA grant funding will be used to continue the process of developing a State Oral Health Improvement Plan for Disadvantaged Persons and to coordinate implementation of the recommendations and objectives. Through the department's reducing oral health disparities initiative to support county health department infrastructure expansion, incremental progress will continue to expand access to low-income and minority populations. As resources permit, specific web-based materials to promote sealants will be developed for the Internet and for distribution as appropriate.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4.6	4.4	4	3.8	3.6
Annual Indicator	4.4	3.8	3.7	3.9	3.6
Numerator	135	118	115	125	119
Denominator	3061306	3100981	3100918	3206178	3269710
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.5	3.4	3.3	3.2	3.1

Notes - 2002

Data for 2002 are not yet available.

Notes - 2003

Data for 2002 are not yet available.

a. Last Year's Accomplishments

Activities to reduce child deaths in motor vehicle crashes include evaluation of children with special health care needs to determine the appropriate child safety seat or restraint and provision of loaner special needs seats or restraints when necessary. Public awareness is raised through the distribution of public safety announcements. In addition, the DOH Office of

Injury Prevention, received a Florida Department of Transportation grant that funded the Florida Special Needs Occupant Protection Program. This program has four sites located in children's hospitals in Orlando, Tampa, Miami, and Ft. Myers. The program staff evaluates children with special health care needs to determine the appropriate child safety seat or restraint, and provides loaner special needs seats or restraints when necessary. The Department of Health is also the lead agency for SAFE KIDS Florida, part of the National SAFE KIDS Campaign, a nationwide effort to prevent injuries to children 14 and under. SAFE KIDS Florida was active in child passenger safety by distributing child safety seats and launching public awareness campaigns.

During this year, we were able to meet our goal and continue to reduce the rate of deaths to children, ages 14 and younger, caused by motor vehicle crashes per 100,000 children. Activities during the reporting year included the activities listed above. In addition, during 2004, the Office of Injury Prevention revised a four-hour presentation based on the updated National Highway Traffic Safety Administration's 32-hour Standardized Child Passenger Safety Training Program. This training on child passenger safety and special needs was developed for nurses and staff within the Children's Medical Services Network. The class includes a PowerPoint presentation with lecture, audience participation activities, hands-on demonstrations and educational handouts. The department distributed over 250 CDs containing Radio Disney produced child passenger safety public service announcements to radio stations throughout Florida.

We implemented the Florida Bicycle Helmet Promotion Program through a Florida Department of Transportation grant that provided over 10,000 bicycle helmets to community partners who fit and distributed the helmets within their community. The single most effective safety device available to reduce head injury and death from bicycle crashes is a helmet. Helmet use reduces the risk of bicycle-related death and injury and the severity of head injury when a crash occurs. More than 56 percent of the children who were riding bicycles and were hit by a motor vehicle suffered a traumatic brain injury, compared to only 45 percent of the children who collided with a stationary object. (Source -- National SAFE KIDS 2004 Fact Sheet) This program is designed to increase the helmet usage among children in low income households, rural counties, and in counties that experience a high incidence of bicycle-related injuries and death.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Evaluation of children with special health care needs to determine the appropriate child safety seat or restraint.	X			
2. Provided loaner special needs seats or restraints when necessary.	X			
3. Purchased 104 special needs child safety restraints and 44 replacement covers and harnesses to be used at the five children’s hospitals.		X		
4. Through the local SAFE KIDS coalitions and state chapters, conducted numerous car seat check-up events on an ongoing basis and during National Child Passenger Safety Week, National SAFE KIDS Week, and Buckle Up America Week.			X	
5. Purchased over 10,000 bicycle helmets that were provided to community partners who fit and distributed the helmets within their community.		X		

6. Raised public awareness of child passenger safety through the public safety announcements aired on Radio Disney and other radio stations throughout Florida.			X	
7.				
8.				
9.				
10.				

b. Current Activities

In 2005, the Special Needs Occupant Protection Program was expanded to an additional children's hospital in St. Petersburg, Florida. The staff is working to expand to three additional children's hospitals, and the program is evaluating special needs children to determine the appropriate child safety seat or restraint, and providing loaner special needs seats or restraints when necessary. Special needs child safety seats or restraints are being purchased for use at the five children's hospitals. An updated four-hour training on child passenger safety and special needs will be provided to staff within the Children's Medical Services network and to staff within Healthy Start coalition offices. Through the local SAFE KIDS coalitions and state chapters, numerous car seat check-up events are conducted on an ongoing basis and during National Child Passenger Safety Week, National SAFE KIDS Week, and Buckle Up America Week. The department is creating additional child passenger safety public safety announcements that will be aired on Radio Disney and other radio stations throughout Florida. We are implementing the 2004-2008 Florida Injury Prevention Strategic Plan that will encourage evidence-based interventions to address motor vehicle injuries, a leading cause of death and injury among children in Florida. The Florida Injury Prevention Advisory Council and the Goal Team Leaders who will be integral to the plan implementation were appointed by Secretary Agwunobi. Staff is working to identify community partners for the Florida Bicycle Helmet Promotion Program and anticipates distributing over 10,000 bicycle helmets to these community partners who will fit and distribute the helmets within their community.

c. Plan for the Coming Year

We submitted a concept paper to the Florida Department of Transportation to continue the Florida Special Needs Occupant Protection Program for 2006. We intend to continue to function as the lead agency for SAFE KIDS Florida and to continue our work in the area of child passenger safety. We will continue implementing our state injury prevention plan. We also submitted a concept paper to the Florida Department of Transportation to continue the Florida Bicycle Helmet Promotion Program for FY 2006. We will also continue activities listed above regarding evaluation of needs, provision of child safety seats or restraints, training, and public awareness activities.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance	65	66	67	70	71

Objective					
Annual Indicator	66.6	68.4	69.6	70.4	65.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	72	73	74	75	76

Notes - 2002

Actual indicator data are not available. Hospital discharge data available to the Department of Health do not track breastfeeding data. The department uses survey data from Ross Laboratories that indicate the percentage of mothers in Florida who are breastfeeding in the hospital.

Notes - 2003

Actual indicator data are not available. Hospital discharge data available to the Department of Health do not track breastfeeding data. The department uses survey data from Ross Laboratories that indicate the percentage of mothers in Florida who are breastfeeding in the hospital.

Notes - 2004

Actual indicator data are not available. Hospital discharge data available to the Department of Health do not track breastfeeding data. The department uses survey data from Ross Laboratories that indicate the percentage of mothers in Florida who are breastfeeding in the hospital.

a. Last Year's Accomplishments

Breastfeeding promotion and support activities, as a part of the WIC and Nutrition Services program, address enabling and population-based services. Populations served are pregnant women, mothers, and infants. Breastfeeding activities are conducted as a form of outreach for the WIC population and the population at large. By tracking breastfeeding rates within WIC, Florida can better gauge its progress with this objective. The WIC population has traditionally had the lowest breastfeeding rates, is considered high-risk, and approximately 50 percent of the infants born in the state are on the WIC program.

During FY2004, the WIC program continued to distribute single-user electric breast pumps for local WIC agencies to provide to WIC breastfeeding moms who are working or in school as a pilot project (enabling service). The distribution of breastfeeding equipment and aids for WIC mothers and babies helps to increase breastfeeding duration for this group, and can have an even broader effect when breastfeeding WIC mothers influence their friends and relatives to also breastfeed their babies longer. The WIC program coordinates with Healthy Start program staff to ensure Healthy start care coordinators offer breastfeeding information, education, and support to pregnant women in-need.

Hospital discharge data available to the Department of Health does not track breastfeeding data. A survey by Ross Laboratories indicates that, in 2004, 65.6 percent of all mothers in Florida are breastfeeding in the hospital. This is a decrease of approximately 5 percent from the previous year.

In FY2004, a statewide audio conference on breastfeeding was sponsored by the obesity

prevention program. The audio conference focused on breastfeeding and building breastfeeding friendly communities. The audio conference reached numerous WIC and Nutrition county health department staff and community partners.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distributed 480 single-user electric breast pumps for local WIC agencies to loan to WIC breastfeeding moms who are working or in school infants as a pilot project in 16 selected WIC local agencies.		X		
2. Tracked “Infants Ever Breastfed” rates and “Infants Currently Breastfed” rates and the “Percentage of WIC Breastfeeding Women/Total Infants for WIC.”		X		
3. Sponsored monthly telephone conference calls for statewide WIC breastfeeding coordinators to share breastfeeding promotion and support activities and ideas.			X	
4. Breastfeeding education and support offered through Healthy Start.		X		
5. Co-sponsored an audio conference with DOH Obesity Prevention on Building a Breastfeeding Community.			X	
6. Enhanced breastfeeding peer counselor programs in 13 WIC local agencies		X		
7.				
8.				
9.				
10.				

b. Current Activities

Data continues to be collected on the single-user breast pump project for working/school WIC moms. Once fully collected, results of surveys will be tabulated. WIC is currently participating in the USDA's breastfeeding peer counselor program and has distributed funds to 13 local WIC agencies for the enhancement of currently established breastfeeding peer counselor programs. Other activities include: continued tracking of breastfeeding indicators for WIC; telephone conference calls for statewide WIC Breastfeeding coordinators; and procurement of breastfeeding equipment and aids, if funding is available.

The program continues to provide breast pumps and breast pump kits, so more women have access to the equipment they need to breastfeed successfully. We continue to monitor breastfeeding rates and the percentage of women in the WIC program who breastfeed. Monthly conference calls with WIC breastfeeding coordinators continue to be held to share breastfeeding promotion and support activities and ideas. The Healthy Start program continues to provide breastfeeding education and support.

c. Plan for the Coming Year

For FY2006, emphasis will be directed to strategies and activities that help WIC mothers to continue breastfeeding, a population with traditionally low breastfeeding rates. We will continue to distribute breastfeeding equipment and information, and continue to track rates. The enhancement of currently established breastfeeding peer counselor programs with funding

from the USDA grant will continue to build their programs and the breastfeeding peer counselor program may be expanded to a few more agencies if funding is available. The WIC program and the Healthy Start program will continue to coordinate their efforts to see that more women and families receive the education and support they need.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	50	75	98	99	99
Annual Indicator	47.7	91.9	98.8	98.0	98.0
Numerator	97258	188200	203113	206806	210700
Denominator	204030	204800	205580	211027	215000
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	99	99	99	99

a. Last Year's Accomplishments

Section 383.145, Florida Statutes, mandates that all babies born in Florida have their hearing screened prior to hospital discharge or within the first 30 days of life. By adding the hearing information to the metabolic specimen collection card, the program collects hearing results on all babies born in the state and sends letters to the families whose babies refer on the hearing screen stressing the importance of the follow up testing. By identifying infants with hearing loss within the first 30 days of life, intervention services can be implemented that should help minimize any speech and language delays that might result. Web-based newborn hearing screening training for nurses, hearing screening technicians, audiologists, speech language pathologists, and physicians was made available. Hospitals were surveyed to provide statistical information regarding births and the number of babies that refer on the hearing screen. The primary population served is children with special health care needs. Technical assistance regarding universal newborn hearing screening training for hospital screening personnel began in July 2003.

Birth hospitals are screening 98 percent of infants born in Florida for hearing loss. Videos, brochures, and web-based training were developed and provided to parents, hospitals, and physicians regarding the importance of universal newborn hearing screening. Individual training is available to hospitals as needed to improve their hearing screening program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribution of educational materials to obstetricians, pediatricians, family practitioners, midwives, parents, hospitals and early intervention providers regarding universal newborn hearing.		X		
2. Providing technical assistance to all Florida birth facilities hearing screening personnel regarding newborn hearing screening.				X
3. Distribution of a family resource guide to families of children with hearing loss.			X	
4. Surveying hospitals to provide statistical information regarding births and the number of babies that refer on the hearing screen.				X
5. Decrease the lost to follow up rate to less than 15%.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A newborn screening brochure including both hearing and metabolic screening is in development for distribution at Florida hospitals. A symposium will be offered in the fall of 2005 to share current information about newborn hearing screening with hospitals and providers. A quarterly column regarding newborn hearing screening appears in the Florida Pediatric Newsletter.

c. Plan for the Coming Year

Educational programs will be developed as needed for hospital screeners, physicians, and parents. New federal funding for this program was applied for and should be awarded in the summer of 2005. The newborn screening database will be enhanced by adding a follow-up module to the existing system. Educational materials will be developed and distributed to obstetricians, pediatricians, family practitioners, midwives, parents, hospitals, and early intervention providers regarding universal newborn hearing. Hospitals will be surveyed to provide statistical information regarding births and the number of babies that refer on the hearing screen. Audiology Centers of Expertise are being explored and developed similar to the referral centers used in the metabolic program. A family support personnel network is being established that will contact families whose babies refer on the newborn hearing screen, stress the importance of the attending hearing appointments, and provide support when children are diagnosed with hearing loss.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	12	10.5	13	15	15
Annual Indicator	13.9	13.9	15.0	15.7	12.1
Numerator	510958	551549	593213	645741	532000
Denominator	3675955	3967977	3962531	4113000	4396354
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	15	15	15	15

Notes - 2002

The KidCare program projects that it will be a difficult to contain any further increase in the percentage of children without health insurance. Florida's projected population growth, coupled with a trend towards fewer benefits for many workers in the private sector, is creating greater need that is not being offset by additional funding for child health insurance. For this reason, we are setting objectives that remain steady through 2007.

a. Last Year's Accomplishments

The 2003 Florida Legislature eliminated state and federal outreach funding for Florida KidCare. Local communities and other entities continued outreach activities without benefit of state or federal funds. The Robert Wood Johnson Foundation's Covering Kids grant, administered by the University of South Florida, also conducted local outreach activities in pilot sites.

A wait list evolved as a result of a 2003 "no growth" budget for Title XXI Florida KidCare. At its height, the Title XXI wait list was 100,433, of which 1,416 were special needs children who met clinical eligibility for participation in the Children's Medical Services Network, which is the state's Title V program for CSHCN.

In March 2004, the Governor signed into law new legislation that provided funding for children who were on the Title XXI wait list through January 30, 2004 -- approximately 90,000 children. The new law also removed statutory authorization for Florida KidCare outreach functions from the Department of Health; instituted new eligibility verification requirements; specified that applications may only be accepted and processed during open enrollment periods, thereby eliminating the accumulation of future wait lists; and required mandatory disenrollments from two of the three Title XXI-funded Florida KidCare program components if enrollment and expenditures exceed appropriations. The legislation exempted the CMS Network from mandatory disenrollment requirements and provided authorization for the CMS Network to enroll up to 120 additional Title XXI-funded children per year outside of open enrollment periods, based on emergency disability criteria.

The Florida Legislature also enacted health insurance reforms recommended by the Governor's Task Force on Access to Affordable Health Insurance and the legislative Task Force on Affordable Health Care for Floridians. Some of the initiatives included statewide availability of flexible health benefit plans, pooled purchasing arrangements for small businesses, and health savings accounts. Implementation of some of these initiatives may have a long-term positive impact on extending affordable health insurance options to working families and children.

The Florida KidCare partners identified policies and procedures needed to implement the

programmatic changes required by the 2004 law, which included statewide notification for the January 2005 Title XXI open enrollment period. In December 2004, the Department published a new application on the Florida KidCare website that incorporated the new documentation requirements. The department also worked with the Florida KidCare partners to ensure public awareness that open and closed enrollment requirements do not apply to Medicaid, and that children who are eligible for Medicaid may be enrolled at any time. Local outreach activities will continue through community-based organizations, the Robert Wood Johnson Foundation Covering Kids grant, and volunteer efforts.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensure families are informed that they can apply for Medicaid using the KidCare application year-round.		X		
2. Policy development and evaluation of effects of Florida KidCare program changes on Florida KidCare enrollment and child uninsurance.				X
3. Provide care coordination and other services to uninsured and underinsured families of children with special health care needs.	X			
4. Statewide notification of KidCare open enrollment.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current activities include the continuation of the regional outreach projects, enabling community-based organizations to place special emphasis on organizations that have direct contact with underserved, uninsured populations. Family advocacy activities are provided locally by the regional outreach projects and statewide through the Florida KidCare call centers. In addition to the multicultural posters and brochures, additional outreach materials were designed and developed including childcare brochures and pamphlets, faith-based partner kits, and immigration issues and eligibility brochures. New statewide partnerships were also implemented with organizations such as the Agency for Work Force Innovation and the Sheriff's Association, who ensure their local agencies promote Florida KidCare. For additional ease of application, the Florida KidCare application and brochure were revised and is now available for families. The application is also available online. Training and technical assistance continues to provide relevant information and outreach strategies to regional outreach projects and local community-based organizations to ensure the effective delivery of Florida KidCare outreach.

In January 2005 the Florida KidCare program held an open enrollment period, during which 96,000 applications were received and continue to be processed for eligibility and coverage. In preparation for the open enrollment period, CMSN staff updated the web site (www.floridakidcare.org) and provided Florida KidCare announcements and materials to community partners.

Retaining eligible, enrolled children in the program is another concern. Due to new income

documentation requirements, there has been a substantial loss of enrollees for non-compliance with renewal requirements. The Florida Healthy Kids Corporation initiated Project Pathfinder, a customer service function focused specifically on retention and informing families about documentation and renewal requirements. The CMS staff created Florida KidCare renewal organizers in English, Spanish, and Haitian Creole to help families understand the renewal requirements and guide them through the process. CMS staff also followed up with families to encourage completion of renewal requirements, accepted faxed information from families, and hand-delivered the information to Florida Healthy Kids, which is responsible for Title XXI eligibility determinations and re-determinations. CMS staff statewide continues to send monthly informational materials to CMS families regarding the renewal process.

c. Plan for the Coming Year

Outreach activities during FY2005 will be limited to several Robert Wood Johnson funded projects and locally-funded county programs. Activities will continue to utilize community-based organizations and will be designed to target insured Florida KidCare families. Outreach will continue to be provided to uninsured, underserved families who are identified by community-based organizations, and health promotion messages will be incorporated in these activities.

Although the Department of Health's formal outreach function was eliminated, staff will continue to work with the other Florida KidCare partners to provide statewide notification when there is a Title XXI open enrollment period. The next open enrollment for Florida KidCare will be no sooner than September 2005, unless further open enrollment modifications are made by the Florida Legislature. The department is monitoring legislative activity closely and will continue to work with the KidCare partners to ensure that the public understands that open and closed enrollment requirements do not apply to the Medicaid program, and that children who are eligible for Medicaid may be enrolled at any time. It is expected that local outreach activities will continue through community-based organizations, the Robert Wood Johnson Foundation Covering Kids grant, and volunteer efforts.

The Agency for Health Care Administration has published an update of the 1998 Florida health insurance study. The new Florida Health Insurance Survey offers preliminary projections of the number of adults and children who are uninsured, statewide and by area. For some areas of the state, estimates of the number who are uninsured are available by zip code. This information is useful in helping the state to analyze the early impacts of changes in the Florida KidCare program, as well as other initiatives such as flexible health benefit plans, and how those changes affected the number of uninsured children in the state.

The Department of Health also will work with the Agency for Health Care Administration and the Department of Children and Families to identify early Medicaid children who may qualify for the CMS Network; continue renewal notification and information activities to help eligible children remain in the program, and identify strategies to serve children with special health care needs for whom neither Title XIX nor Title XXI funding is available. It is expected that the need for services will exceed available funds in the sate-funded safety net program; however, CMS staff will continue to offer care coordination and referrals to other community resources to families throughout FY 2004-2005.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	87	90.9	91.5	92.6	94.3
Annual Indicator	90.4	89.9	92.3	94.1	99.9
Numerator	1124413	1226782	1316733	1495721	1582969
Denominator	1243809	1364950	1426472	1589640	1583850
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	94.5	94.8	95	95.2	95.4

a. Last Year's Accomplishments

Although the state legislature eliminated Florida KidCare outreach functions from the Department of Health in 2003, local organizations and communities worked together to continue outreach activities. The Florida KidCare partners' goal was to ensure the public understood families may apply for and have their eligible children enrolled in Medicaid at any time. Data from the Agency for Health Care Administration indicate the percentage of Medicaid-eligible children who received a service rose to 99.9 percent in FY2004, compared to 94.1 percent in FY2003.

We continued to work with local communities and independent entities without benefit of state or federal funds, to educate families and other stakeholders on the importance of well-child visits and health insurance coverage for children. The Robert Wood Johnson Foundation's Covering Kids grant, administered by the University of South Florida, also conducted local outreach activities, emphasizing the very important message that families can apply to Medicaid at any time of the year.

The Florida KidCare program partners conducted a series of state and regional meetings to solicit public input about ways to ensure Florida families understand that closed enrollment and other new requirements for the Title XXI program components do not apply to the Medicaid program. In addition, strategies have been developed and implemented to ensure accurate and understandable communications occur between state agencies and local entities that work with affected families.

The 2004 Legislature also enacted changes to the time frames Medicaid beneficiaries have to make a voluntary selection of a MediPass primary care provider or a managed care plan. Effective July 1, 2005, Medicaid individuals were given 30 days in which to make a voluntary choice selection. After that, they will have 90 days to withdraw from the assigned provider and make another selection.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase public awareness of KidCare.		X		

2. Make the application process for Medicaid more accessible.		X		
3. Recruit community partners to assist in access and informational activities.		X		
4. Develop a child health strategic plan to strengthen the health care system for children.				X
5. Increase focus on the eligibility process at county health departments.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In December 2003, the department's Child and Adolescent Health Unit applied for and received federal funding to assist with the development of a coordinated system of care for children age 0-5. The Early Childhood Comprehensive Systems Project will target children 0-5 and children with special healthcare needs, to improve access to care and improve the health of infants and young children. This planning process includes representatives from multiple agencies and organizations. State and regional planning meetings will be held throughout 2005.

While it was anticipated that due to the use of the umbrella Florida KidCare program, which includes both Title XIX Medicaid for children and Title XXI-funded program components, there might have been a decline in Medicaid enrollments as a result of the new documentation requirements and restriction of new applications to specific open enrollment periods, this did not occur. In fact, the December 2003 Title XIX Medicaid enrollment was 1,176,007, and the enrollment in December 2004 was 1,204,874. While there were a few minor fluctuations in the Title XIX enrollment figures during the year, Medicaid maintained more than a 2 percent growth rate over the 12-month period.

The Florida KidCare program continues to work with its community partners to get the word out that regardless of any restrictions in open enrollment periods for the Title XXI programs, Medicaid is always available to families. They can submit applications to that program at any time during the year, and eligible children can be immediately enrolled.

c. Plan for the Coming Year

For FY2005, CMS will continue to participate in the state and regional planning meetings for the Early Childhood Comprehensive System Project.

The Florida KidCare partners will continue to work with community-based organizations, health care providers, and others to ensure people understand the Medicaid program is always open, and eligible children may be enrolled at any time during the year. In addition, the Robert Wood Johnson Foundation Covering Kids project plans to implement special initiatives to work with hard-to-serve populations and leaders in minority communities to make sure that they know Medicaid is available to eligible children year-round. These enabling services will be targeted towards providing easy-to-understand, accurate information about the Medicaid program, and preventing loss of coverage among eligible children in the state.

The CMS program will ensure Medicaid-eligible children with special health care needs are enrolled in the program. CMS also will work with the Department of Children and Families on including special needs questions in the initial Medicaid eligibility determination process and for eligibility redetermination. The goal will be to identify early Medicaid-eligible children with

special health care needs to inform their families about the CMS Network and the specialized health benefits it offers. If children are identified early and select the CMS Network before being subject to mandatory assignment, it can prevent breaks in continuity of care and ensure the children are enrolled in a system of care that uses pediatric providers and specialists.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.5	1.5	1.5	1.5	1.5
Annual Indicator	1.5	1.6	1.6	1.6	1.6
Numerator	3115	3303	3324	3319	3454
Denominator	203732	205800	205580	212243	217124
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.4	1.4	1.3	1.3	1.2

a. Last Year's Accomplishments

Florida's Healthy Start program reaches out to high-risk pregnant women and provides enabling services such as health education, smoking cessation, nutritional counseling, psychosocial counseling, and cessation of drug use during pregnancy. Healthy Start coalitions work to ensure an adequate infrastructure is in place. This includes the provision of community needs assessment, quality assurance and monitoring of prenatal care providers, and coordination of systems of care to promote adequate access to prenatal care for all pregnant women. Through implementation of the Healthy Start Medicaid Waiver program, the intensity and duration of services for pregnant women and children at highest risk have been increased.

Fetal and Infant Mortality Review projects across the state assist in the development of infrastructure needed to meet the needs of the maternal and child health population by helping to identify system-wide factors that may contribute to fetal and infant deaths and low birth weight. Through the FIMR process, we continue to gain knowledge to improve prenatal care systems and contribute to the prevention of very low birth weight births.

During FY2004, the rate of very low birth weight births remained steady at 1.6 percent, which did not meet our projected goal of 1.5 percent. Unfortunately, both nationally and in Florida, the reasons for an apparent "leveling off" over the past several years and continued difficulty in reducing this rate are poorly understood. Many efforts were made to reduce the rate, such as attempts to raise the Healthy Start screening rate to identify more women at risk of poor pregnancy outcomes.

Through the Healthy Start prenatal care coordination program, outreach was provided to help

women access prenatal care earlier, and other services were provided to help reduce risks of poor birth outcomes, such as smoking cessation, nutritional counseling, psychosocial counseling, and support of cessation of drug use during pregnancy. We worked with the March of Dimes to promote awareness of the need for women of childbearing age to consume 400 mcg of folic acid daily.

As county health departments underwent quality assurance/quality improvement visits by department staff, discussions of county initiatives related to reductions in racial disparities, interventions for substance-abusing pregnant women, and other maternal and child health issues allowed for targeted technical assistance to be provided as communities try to reduce rates of very low birth weight infants.

We established an Infant Mortality Review Project to provide technical assistance to communities. Teams were comprised of the DOH county liaisons along with the Healthy Start contract managers, Healthy Start coalitions, and CHD staff. The focus was on birth weight specific mortality analysis, examining trends in cause of death, GIS mapping of low birth weight incidence and prevalence, and use of other data sets.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue our focus on Healthy Start prenatal care and care coordination services to pregnant women identified at risk for poor birth outcomes.		X		
2. Apply the knowledge gained from the Florida Birth Defects Surveillance System, including the Birth Defects Registry, to improve our system of care.				X
3. Increase number of pregnant women offered risk screening, improve outreach to increase percentage of women receiving prenatal care during the first trimester, and promote family planning services to increase birth intervals and reduce teen births.		X		
4. Partner with the March of Dimes to reduce the rate of premature births in Florida.				X
5. Continue to use the valuable knowledge gained from Fetal and Infant Mortality Review (FIMR) projects to improve our system of care.				X
6. Increase collaboration among community providers and Healthy Start coalitions to improve local systems of care for our maternal and child populations.			X	
7. Study factors related to racial disparity.			X	
8. Continue statewide interventions targeted at prevention and cessation of drug use during pregnancy.			X	
9. Continue statewide interventions targeted at prevention of bacterial vaginosis and other infections in pregnancy.			X	
10. Continue the Healthy Start Medicaid Waiver initiative to increase the intensity and duration of Healthy Start services.			X	

b. Current Activities

The department is currently engaged in the following activities to reduce the rate of very low birth weight infants to 1.4 percent of live births. We continue our focus on Healthy Start prenatal

care and care coordination services to pregnant women identified as at risk for poor birth outcomes. There is a statewide effort to increase the number of pregnant women offered the Healthy Start risk screening, and there are continuous efforts to improve availability and promote the use of family planning services to increase birth intervals and reduce teen birth rates.

Emphasis is being placed on preconceptional and interconceptional education and counseling through the Healthy Start Programs as well as county health department clinical health programs. Collaborations between Healthy Start coalitions and community providers continue to improve public health infrastructure by analyzing local systems of care for maternal and child health populations.

In areas of the state where racial disparities in birth outcomes are most marked, Healthy Start coalitions work with leaders and members of minority communities to develop targeted programs to reach out to minority pregnant women to ensure access to prenatal care and care coordination. Healthy Start coalitions also work statewide in prevention and cessation of drug use during pregnancy, as well as education on the importance of prevention and early identification of maternal infections during pregnancy.

We collaborated with the Area Health Education Centers to provide regional in-service training to physicians, nurses and other health care workers on effective strategies for assisting patients to stop smoking.

c. Plan for the Coming Year

In FY2005, we will continue to work through the Healthy Start program to identify those women at highest risk for poor birth outcomes and provide interventions known to help decrease these risks. Emphasis will continue to be placed on addressing the issue of prenatal smoking. We will continue our statewide effort to bring more high-risk women into Healthy Start by increasing the Healthy Start screening rate, and we will continue to provide increased intensity and duration of services to high-risk women through the continuation of the Healthy Start Medicaid Waiver.

We plan to continue our collaborative relationship with the March of Dimes in order to address prematurity in Florida. FIMR data will continue to be used as a valuable tool to improve systems of care for pregnant women. Prenatal health guidelines are being updated and preconceptional health guidelines are being implemented. A new prenatal guidebook will be available with a special emphasis on importance of being healthy prior to pregnancy.

Alternative prenatal care delivery methods, such as group prenatal care, will be piloted in various regions of the state to determine if the very low birth weight rates can be reduced by altering the method in which prenatal care is delivered.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective	6.9	6.8	6.7	6.6	6.5
Annual Indicator	6.1	6.7	7.0	5.2	5.3
Numerator	58	70	75	58	61
Denominator	957537	1051356	1071066	1111667	1140989
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6.4	6.3	6.2	6.1	6

Notes - 2002

On this measure, the objective for next year is set higher than the indicator for this year. This is because data for 2002 are provisional and do not reflect all the suicides that may have occurred.

a. Last Year's Accomplishments

During FY 2004, county health department and school district school nurses and social workers provided assessment and referral of students to mental health services when students present with evidence of mental health issues, suicidal ideation, or risk behaviors. These nurses and social workers also provided small group prevention-intervention activities to high-risk students and prevention health education classes to school classes and assemblies. Topics of the activities and education classes include suicide, mental health, alcohol and other drugs, violence, and conflict resolution.

During FY2004, the suicide rate per 100,000 for 15 to 19-year-olds increased slightly from 5.2 for 2003 to 5.3 for 2004 (provisional). During 2004, county health department Comprehensive School Health staff referred 4,929 students to community-based mental health services. They also provided 3,608 mental health prevention-interventions to 14,576 students; 2,981 mental health education classes to 123,784 students; 253 suicide prevention-interventions to 1,107 students; 922 suicide prevention classes to 21,902 students; 1,501 violence prevention/conflict resolution interventions to 14,947 students; 3,168 violence prevention/conflict resolution classes to 117,329 students; 1,038 alcohol, tobacco and other drug prevention interventions to 5,667 students; and 5,559 alcohol, tobacco, and other drug prevention classes to 246,792 students.

The Florida Department of Health is a member of the Florida Suicide Prevention Taskforce. The taskforce met throughout the year and created a youth committee to address the problem of suicide in those 24 and younger. One goal is to reduce the rate of youth suicide in Florida by one-third (from approximately 5.0 per 100,000 in 2005 to approximately 3.33 per 100,000 in 2010). The Florida Suicide Prevention Taskforce also coordinated a third Suicide Awareness Day at the state capitol in Tallahassee.

As a collaborative effort of the Florida Suicide Prevention Taskforce, the Department established a Department of Health Suicide Prevention Workgroup in 2004. Membership includes representation from Injury Prevention; Child and Adolescent Health; School Health; Infant, Maternal and Reproductive Health; Children's Medical Services; Sexual Violence; HIV/AIDS; public health nursing directors; and county health department administrators.

Columbia University's Teen Screen has now been implemented by the Wakulla County Health Department and the Wakulla County school district.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Suicide prevention small group prevention-interventions and health education classes in Comprehensive School Health Services Projects.		X		
2. Youth suicide prevention train-the-trainer workshops for gatekeepers.			X	
3. Coalition building by the Florida Suicide Prevention Taskforce.				X
4. Utilization of proven mental health / screening programs.			X	
5. Implementation research-based suicide prevention pilot projects.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During 2005, school nurses and social workers from the comprehensive school health services project schools continue to refer students for community-based mental health services. Staff continues to provide prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

Through the Florida Suicide Prevention Taskforce, Department of Health staff is working on the following objectives: (1) develop broad-based partnerships/collaboration for suicide prevention; (2) develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention; (3) develop and implement community/youth-based suicide prevention programs; (4) promote efforts to reduce access to lethal means and methods of self-harm; (5) implement training for recognition of at-risk behavior and delivery of effective treatment; (6) develop and promote effective clinical and professional practices (7) improve access to and community linkages with mental health and substance abuse services; and (8) improve and expand surveillance systems. The Florida Suicide Prevention Taskforce completed the Florida Suicide Prevention Strategy 2005-2010 and it was rolled out at the fourth annual Suicide Awareness Day, March 30, 2005, by Governor Jeb Bush at the state capitol in Tallahassee.

In April 2005, the department's Suicide Prevention Workgroup provided a four-hour program at the statewide Department of Health Public Health Nursing Directors meeting on depression and suicide prevention issues and community resources.

c. Plan for the Coming Year

During FY2006, school nurses and social workers from the comprehensive school health services project schools will continue to refer students for community-based mental health services. Staff will also provide prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

The Florida Suicide Prevention Taskforce will continue to meet and coordinate strategy implementation and suicide prevention activities. The Department of Health Suicide Prevention Workgroup will continue to meet and provide information and awareness activities for the department's local programs.

School health nurses and social workers will be key in helping to identify and implement school health programs with the assistance of the Youth Suicide Prevention School-Based Guide, released 2003 by the Florida Institute of Mental Health at the University of South Florida. The guide is available on the Internet at the following address: http://cfs.fmhi.usf.edu/StateandLocal/suicide_prevention/. During 2006, school health social workers will be key players in helping school districts complete the District Safety and Security Self-Assessment Form 2002-2003 created by the Florida Department of Education, Office of Safe Schools, in response to the Safe Passage Act -- Section 1006.07 of the Florida Statutes. The form can be viewed at the following site: http://www.firn.edu/doe/besss/safe_passage/2003doc/2002_best_practices_and_indicators.doc. It is anticipated that Teen Screen will be implemented in schools in those counties where there are sufficient licensed clinical social workers or psychologists.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	87.5	90	90	90	90
Annual Indicator	87.8	84.4	86.2	83.1	86.8
Numerator	2738	2788	2864	2737	2891
Denominator	3119	3303	3324	3293	3331
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

a. Last Year's Accomplishments

Infrastructure-building activities during the past year to increase the percentage of very low birth weight infants being born at a high-risk facility included: four of the Regional Perinatal Intensive Care Centers (RPICC) providing 12 high-risk obstetrical satellite clinics; RPICC staff at the 11 designated facilities provide a comprehensive high-risk obstetrical outpatient clinic; and RPICCs are monitored annually by physician consultants to ensure the quality of care for the high-risk obstetrical patients and appropriate placement for neonates in the Level III NICUs. Enabling activities included the provision of yearly educational programs to the community health providers by RPICC staff. In addition, transportation was provided through a contract for RPICC eligible high-risk pregnant women to a RPICC and for neonates requiring care at a Level III NICU. The populations served are high-risk pregnant women and low birth weight or sick infants.

During FY2004, 86.8 percent of very low birth weight infants were delivered at high-risk facilities. The goal of 90 percent was not reached; however, there was an increase from the

83.1 percent rate reported for 2003.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Regional Perinatal Intensive Care Centers (RPICC) staff from four of the RPICCs provides 12 high-risk obstetrical satellite clinics.	X			
2. RPICC staff at the 11 designated facilities provides a comprehensive high-risk obstetrical outpatient clinic.	X			
3. RPICC staff provides yearly educational programs to the community health providers.			X	
4. RPICCs are monitored annually by physician consultants to ensure the quality of care for high risk obstetrical patients and appropriate placement of neonates in the Level III NICUs.				X
5. Transportation is provided through a contract for high risk obstetrical patients to facilities with Maternal Fetal Medicine physicians and for neonates requiring care at a Level III NICU.		X		
6. Identify hospitals that are inappropriately delivering low birth weight infants, to provide education and linkage to an appropriate facility for high risk mothers and infants.		X		
7.				
8.				
9.				
10.				

b. Current Activities

The following types of public health services continue to be provided through the RPICCs and by the RPICCs staff: direct health care services are provided at the RPICCs (inpatient and outpatient) and through the 12 high-risk obstetrical clinics located at varying distances from the RPICCs; enabling services are provided, including transportation for high-risk obstetrical patients to a RPICC facility with a maternal fetal medicine physician and for low birth weight neonates that require Level III NICU services (this service is provided by a contract with one of the RPICCs), and an educational program offered by the RPICC staff to the community health providers; and infrastructure-building services are provided through the annual quality assurance monitoring of the RPICCs to ensure that standards of care are being met. Our goal is to ensure that high-risk obstetrical patients and very low birth weight newborns are delivered and receive care at appropriate level hospitals.

c. Plan for the Coming Year

The goals for FY2006 are to ensure that 90 percent of very low birth weight infants are delivered at appropriate hospitals with NICU services, and to increase the number of RPICC high-risk obstetrical satellite clinics in the South Florida area in order to increase access of high-risk obstetrical services for more women. RPICC staff will continue to provide services at satellite clinics to decrease the number of low birth weight infants by providing easier access to high-risk obstetrical maternal care and education. CMS will continue to provide educational programs to community health providers. CMS will continue to monitor RPICCs to ensure appropriate placement of neonates in the Level III NICUs. Emergency transportation will be provided through a contract to relocate high-risk obstetrical patients to a RPICC facility with a

Maternal Fetal Medicine physician and to move low birth weight neonates requiring care at a Level III NICU. The RPICC staff will identify delivering facilities that inappropriately deliver very low birth weight neonates, and encourage the establishment of linkages necessary to transfer high-risk obstetrical women to appropriate delivering facilities.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	84	84.5	85	85.7	86
Annual Indicator	83.8	84.1	85.4	85.8	80.7
Numerator	169059	171080	173475	180107	145907
Denominator	201747	203337	203158	209801	180877
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86.3	86.6	87	87.2	87.4

a. Last Year's Accomplishments

The department worked in collaboration with Healthy Start coalitions statewide to ensure an adequate infrastructure is in place for the provision of first trimester prenatal care and continuous care for all pregnant women. We worked with Healthy Start coalitions to promote awareness among providers that Medicaid pays additional reimbursement to providers who screen their clients for Healthy Start during the first trimester. Through the development of policies such as those aimed at preconceptional health, we promoted wellness among women of childbearing age and helped educate women on the importance of first trimester entry into care.

Quality assurance/quality improvement (QA/QI) visits to county health departments helped CHD staff identify systems issues that may act as barriers to first trimester prenatal care, and allow maternal and child health staff to provide targeted technical assistance and training to counties that have first trimester entry levels below the state average. Healthy Start coalitions also provided or facilitated a variety of enabling services, depending on local needs and resources, such as translation services, outreach, health education, family support services, case management, and coordination with WIC and Medicaid. All of these enabling services served as supports to encourage and help women to access early prenatal care. In some communities there are few resources or options for prenatal care, especially for women who are uninsured and do not qualify for Medicaid. In these communities, the coalitions may provide financial support for the provision of direct health care services (prenatal care), as this is the only way these services are available to some of the women at highest risk.

The MomCare program, implemented statewide during FY2002, facilitates Medicaid coverage for prenatal care under the Sixth Omnibus Budget Reconciliation Act (SOBRA). MomCare provides prenatal care choice counseling, helps women access health care services, assists in follow-up of missed prenatal care appointments, and promotes coordination between prenatal care providers and supportive health related enabling services. We continued to ensure the statewide process of simplified Medicaid eligibility for pregnant women. Additionally, we worked through the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue work through Healthy Start coalitions to encourage providers to see patients during the first trimester of their pregnancies.			X	
2. Continue targeting counties with first trimester entry levels below the state average for special technical assistance, and develop and implement strategies to improve access to early prenatal care.				X
3. Continue to promote the use of the preconceptional health guideline in the county health departments.				X
4. Continue the MomCare program.		X		
5. Continue Presumptive Eligibility and Simplified Eligibility Medicaid application processes to expedite entry into prenatal care.		X		
6. Continue working through the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Florida Department of Health is currently engaged in the following activities to increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester: We continue to work with Healthy Start coalitions to promote awareness among providers that Medicaid pays additional reimbursement to providers who screen their clients for Healthy Start during the first trimester.

Through QA/QI visits to county health departments across the state, we continue to meet face-to-face with administrators, managers, and front-line staff and talk to them about local issues that may be presenting barriers to first trimester entry into prenatal care in their communities. This allows us to provide targeted technical assistance and consultation to communities as they work on infrastructure-building and maintenance activities to help ensure access to first trimester prenatal care.

We continue with the MomCare program to assist pregnant women in obtaining prenatal appointments and following up on their medical care. We encourage the CHDs to provide Presumptive Eligibility for Pregnant Women, which allows immediate access to Medicaid services. We also are encouraging providers outside of the CHD to use the Simplified Eligibility Medicaid application. This streamlined process requires no face-to-face contact, reducing some

of the stigma barriers in accessing Medicaid insurance.

We have implemented the preconceptional health guidelines for the county health departments. These guidelines include, but are not limited to, promotion of wellness among women of childbearing age and emphasis on the importance of educating women on the importance of entry into prenatal care during the first trimester. The Healthy Start program has also added interconceptional health and education to their service delivery model.

c. Plan for the Coming Year

We will continue to work through Healthy Start coalitions to encourage providers to see patients during the first trimester of their pregnancies, and we will continue to partner with the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate. We will also continue targeting counties with first trimester entry levels below the state average for special technical assistance, and develop and implement strategies to improve access to early prenatal care. This will be accomplished through continued QA/QI visits to counties, as well as through working in collaboration with Healthy Start coalitions statewide. We also plan to continue the MomCare program and the simplified eligibility Medicaid application process statewide.

Through a collaborative relationship with the March of Dimes Florida Chapter, we will be placing a position within the DOH Division of Family Health Services to focus on preconceptional and interconceptional health. Part of this focus is the emphasis on educating women, prior to pregnancy, about the importance of accessing prenatal care during the first trimester when they do become pregnant.

The Florida Department of Health is currently researching an alternative prenatal care model known as Centering Pregnancy. This group care model consists of assessment, education, and support. It is gaining much popularity in clinics around the nation, especially with those targeting high-risk populations. This model encourages women to take an active part in their prenatal care and empowers them through self-help and support activities. The Florida Department of Health is looking to pilot some group prenatal care projects in the future. The focus will be on areas that have access to care barriers and low continuation of prenatal care.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percentage of Part C eligible children receiving service*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80%	85%	90%	92	95
Annual Indicator	83.4	90.0	101.1	96.2	97.2
Numerator	29996	32282	37466	39333	40554
Denominator	35983	35886	37060	40879	41731

Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	98	98

Notes - 2002

During FY2002, 101 percent of the estimated number of eligible Early Intervention Program infants and toddlers received services, as the number served exceeded the estimate of how many would be eligible.

Notes - 2003

Note: During FY2002, the estimated number of eligible Early Intervention Program infants and toddlers receiving services exceeded the estimate of how many children would be eligible. During FY2002-2003, we estimated an increase of about 5% of children needing services, and we served 95% of those children. Some children's parents choose not to participate, and another proportion are not being found or reported for services.

a. Last Year's Accomplishments

Direct health care activities related to this measure include identifying, evaluating, and providing services to eligible infants and toddlers through contracts with 16 regional programs. The Early Intervention Program also provided enabling activities such as reducing caseload sizes; providing advocacy, training and support services for families; and coordinating with Medicaid and other agencies to access funding and support for the service delivery system. Population-based services included providing ongoing outreach, public awareness, and education. Examples of infrastructure-building services activities included designing a methodology for the evaluation of the current service delivery system; developing and implementing state policy and standards; implementing a centralized system for provider enrollment, training, tracking, and management; initiating a comprehensive system of personnel development; and conducting quality assurance reviews and follow-up to ensure compliance with federal regulations and state policy. This measure was chosen because determining the percentage of potentially eligible children offered early intervention services is an excellent indicator of the effectiveness of our CSHCN system. The measure is related to the priority needs to prevent the incidence of disabilities for infants and children, and decrease the incidence of child morbidity. This measure is related to the outcome measures for reducing infant, neonatal, postneonatal and perinatal mortality. Preventing the incidence of disabilities for infants and children is a state priority. It addresses the continuing need to provide adequate screening, assessment, and services to ensure infants and children receive the services they need to help them lead more healthy lives.

During FY2004, 97 percent of the estimated number of eligible Early Intervention Program infants and toddlers received services. Public input was obtained related to service delivery policies and implementation of the revised policies began July 1, 2004.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Evaluate current service delivery system to improve services for infants and toddlers with disabilities and their families.			**X**	
2. Provide ongoing outreach, public awareness and education.		**X**		

3. Identify, evaluate and provide services to eligible infants and toddlers through contracts with 16 regional programs.	X			
4. Reduce service coordination caseload size to no more than 1/65.		X		
5. Develop and implement state policy and standards for providing services in natural environments, and implement a centralized system for provider enrollment, training, tracking and management.			X	
6. Implement Comprehensive System of Personnel Development as required in the IDEA, Part C Federal Regulations.				X
7. Conduct Quality Assurance Reviews and follow-up Corrective Action Plans to ensure compliance with Federal Regulations and State Policy.				X
8. Provide advocacy, training and support services for families.			X	
9. Coordinate with Medicaid, Insurance, Department of Education and other agencies to access funding and support for service delivery system.				X
10. Design and Implement statewide system evaluation for Early Steps.				X

b. Current Activities

The focus of how early intervention services are delivered in Florida is a major program initiative. The policy paper outlining Florida's new system was revised February 1, 2005 to further clarify statewide policies on the design and implementation of a new service delivery system. Technical assistance is being provided to ensure compliance with program policy. Instructor led and online training modules are being developed to ensure that staff and providers have the knowledge and skills necessary to implement the enhanced service delivery system.

A public awareness plan is being implemented to increase awareness of the Early Intervention Program and referral process and procedures. A change in program name from Early Intervention Program to Early Steps has been accomplished. Public awareness materials are being created and disseminated to promote the new name. The accessibility and navigation of the program website is being enhanced. The new name and look has increased the awareness level of the general public related to the purpose and goals of the Early Steps system.

The Individuals with Disabilities Education Act was reauthorized in December 2004 and new requirements must be implemented beginning July 1, 2005. A workgroup continues to meet to design an evaluation plan for the Early Steps service delivery system. A federal grant has been awarded to assist the program in the design of the evaluation process.

c. Plan for the Coming Year

The goals for FY2006 are to continue to implement the infrastructure described under the state performance measures and the system evaluation for Early Steps. State policies will be revised to address the new requirements in the Individuals with Disabilities Education Act. Infrastructure-building activities will continue, ensuring federal requirements are being met and services are provided within the resources of the state, services are provided within natural environments, and a service coordinator ratio of 1/65 is reached. Enhancements to the family involvement infrastructure will be implemented. Further revisions to the Quality Assurance and Continuous Improvement Monitoring and Technical Assistance System are planned for the upcoming year. The Personnel Development and Training Guide will be revised to incorporate requirements associated with the implementation of the enhanced service delivery system. Coordination will continue with Medicaid, Insurance, the Department of Education, and other agencies to access funding to support increased numbers of children eligible for services. Development of a methodology for evaluation of the Early Steps system will continue with the support of a federal project to evaluate child and family outcomes.

State Performance Measure 3: *The percentage of pregnant women reporting domestic violence on the PRAMS survey*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7%	7.2%	7.4%	7.6	7.8
Annual Indicator	4.9	4.8	4.4	4.9	
Numerator	9719	9663	8817	10050	
Denominator	197380	200173	199442	205207	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8	8.2	8.4	8.6	8.7

Notes - 2002

Data for 2001 and 2002 are not yet available. The data are PRAMS data, and have not been received from CDC. The data may be available sometime in July, and we could calculate the indicator data from that, probably by late August.

Notes - 2003

Data for 2002 and 2003 are not yet available.

Notes - 2004

Data for 2004 are not yet available.

a. Last Year's Accomplishments

During FY2004, technical assistance continued for domestic violence related-issues at the state and county health department level, including implementation of the Department's technical assistance guidelines, safety planning, and referral systems. Participation in pregnancy associated mortality reviews, domestic violence fatality review teams, and community task forces was also encouraged and supported.

Comprehensive assessments and specific referrals for a client who discloses abuse are coded to the statewide Health Management Component Reporting System. This occurs in several program areas, including immunizations, STDs, HIV/AIDS, TB, Hepatitis, WIC, family planning, improved pregnancy outcome, Healthy Start (county health department providers only), comprehensive child health (when age appropriate), comprehensive adult health, dental, and general personal health. According to HMCS data, approximately 31,000 women received safety planning and/or referrals to local DV centers in calendar year 2004. An increase in numbers was evident in those counties most greatly impacted by the hurricanes.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitoring adherence to the technical assistance guidelines on domestic violence screening, identification, treatment and referral.				X
2. Updating the domestic violence screening documentation form for efficiency and ease of use based on ongoing recommendations provided by nursing staff in the field.				X
3. Tracking DV referrals from health departments through the universal screening code on domestic violence interventions, in the statewide Health Management Component Reporting System.				X
4. Providing technical assistance to state and local partnerships between county health departments and domestic violence centers.				X
5. Participating in national conferences and conference calls pertaining to domestic violence and/family violence; and participating in statewide MCH liaisons conference calls, CHD Director conference calls, and Family Planning conference calls to explo			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Ongoing conference calls are conducted to discuss systems of care related to domestic violence in counties. Maternal and child health staff members continue to participate on Pregnancy Associated Mortality Review teams, presenting a domestic violence perspective during the review process. Intra-agency and interagency linkages are being sought out to encourage awareness of the program and incorporation of domestic violence intervention into several service delivery points.

The technical assistance guidelines are being revised based on feedback from administrative and county health department field staff. These proposed guidelines will address the unique issues that public healthcare systems must consider when implementing universal screenings. In addition, the screening form, DH3202, is currently undergoing a second revision based on feedback from attorneys and healthcare professionals in the field who utilize the form.

c. Plan for the Coming Year

The department will continue to provide technical assistance and updated information to domestic violence liaisons, coding staff, nursing staff and health educators at county health departments. The program is seeking funding to conduct intensive training for county health departments and other community partners on domestic violence and its impact on the community.

State Performance Measure 4: *The percentage of subsequent births to teens age 15 to 19*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	15.6%	15.4%	15.3%	15.5	15.2
Annual Indicator	16.0	15.5	14.8	15.2	15.4
Numerator	5436	5130	4663	4530	4316
Denominator	34013	33056	31609	29749	28048
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15.2	15	14.8	14.6	14.4

a. Last Year's Accomplishments

Activities designed to reduce subsequent births to teens consist of small-group pregnancy prevention interventions, case management, family planning counseling and education services, comprehensive contraceptive services, abstinence education, peer education and mentoring, and collaboration with other programs that work to reduce teen pregnancy. During FY2004, the provisional data indicate that 15.3 percent of youth age 15 to 19 who had previously given birth had subsequent births, which is lower than the annual objective of 15.5.

A number of activities were conducted to address this issue. The statewide family planning program provided services at local county health departments and contract agencies to 52,562 youth age 15 to 19 during calendar year 2004. County health departments and local contract providers train and work to improve pregnancy prevention strategies for youth. An important initiative in the effort to curtail subsequent teen births is special educational activities that highlight the role of coercive sexual practices by men, particularly older men. Local public and private family planning units provide services that address males' responsibility in teen pregnancy while educating males about coercive sexual behavior.

The Healthy Start program provides universal risk screening for pregnant women and their newborn infants to identify those at risk for poor birth, health, and developmental outcomes. Healthy start participants receive family planning counseling throughout their pregnancy. Healthy Start staff provides clients with information on the various methods of birth control to assist them in making an informed decision concerning their preferred method of family planning.

Comprehensive school health services projects (CSHSP) in 342 schools with high-risk populations provided prevention and intervention services for pregnant and parenting teens. There were 71 subsequent births (7.51 percent) in CSHSPs during FY2004. Services included facilitated small group activities, case management, and care coordination to help students access support services, stay in school, return to school after delivery, and learn to avoid subsequent births. Project staff worked closely with Healthy Start programs, Healthy Families Florida home visitors, school district teen parent programs, and case managers from the Department of Children and Families. Workforce development activities included measures to help youth break the cycle of teen pregnancy and welfare dependence.

Third party evaluation of Florida's Family Planning Waiver Program showed that the waiver had

a positive impact on subsequent birth rates and costs to the Medicaid Program for women who chose to utilize family planning services, particularly for teens. This is very significant since the avoidance of a second birth by a teen is highly correlated with a reduction in poverty, increased high school graduation rates, and reduction in child maltreatment.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Small group pregnancy prevention interventions in Comprehensive School Health Services Projects.	X			
2. School Health case management and care coordination in Comprehensive School Health Projects to enable parenting students to remain in school and graduate.		X		
3. Provision of confidential family planning counseling and education services.	X			
4. Provision of confidential family planning comprehensive contraceptive services.	X			
5. Collaboration of Department of Health programs working to reduce teen pregnancy.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The statewide family planning program continues to provide services in all 67 counties. In addition to providing an array of services, the family planning program has received approval from the Center for Medicaid and Medicare Services to implement a revised family planning Medicaid waiver. Through the department's quality improvement process, the family planning program assesses county health departments for teen accessibility and provides technical assistance on teen pregnancy prevention and program strategies for serving the teen population.

CSHSPs continue operating in 46 counties, providing small group prevention and intervention services on pregnancy prevention, case management, and care coordination to prevent subsequent births to parenting students. To help accomplish this, projects continue to work closely with county health department Healthy Start programs, Healthy Families Florida home visitors, school district teen parent programs, abstinence programs, and case managers from the Department of Children and Families. The department's team that is working on a specific problem solving methodology to reduce subsequent teen birth will complete a report with recommendations for the department and county health departments by the end of the fiscal year.

c. Plan for the Coming Year

During FY2006, our plan to reduce subsequent births to teens 15 to 19 to 15 percent will include the provision of family planning services in all 67 counties, health education and health

services at schools, Healthy Start services, and abstinence education services. County health departments, Healthy Start coalitions, and agencies and programs involved in welfare reform will continue to educate and collaborate with other community agencies in reducing teen births.

The CSHSPs will continue to operate in 46 counties to provide small group prevention and intervention services on pregnancy prevention, and case management and care coordination to prevent subsequent births to parenting students. These services will be coordinated closely with all programs and agencies as in past years. Collaboration will continue among department programs working with teens through the sharing of information and resources. Strategic planning efforts regarding teen pregnancy prevention and intervention will continue to be a priority.

County health departments, local contract providers, Healthy Start programs, Healthy Families Florida programs, and other agencies that provide maternal and infant care services will inform postpartum women about extended family planning through Medicaid family planning waiver services. These providers will have access to applications and client information brochures to distribute to youth to increase awareness and use of family planning services under the special Medicaid program. It is anticipated there will be a reduction in the number of subsequent births for teens that access and utilize family planning services. If for some reason the youth is not eligible to participate in the waiver program, family planning services can be provided under the department's Title X program.

State Performance Measure 5: *The percentage of women reporting tobacco use during pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	10%	9.7%	9.5%	8.4	8.2
Annual Indicator	9.4	9.1	8.6	8.1	9.0
Numerator	19205	18691	17674	17165	19568
Denominator	203732	205800	205580	212243	217105
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8	7.8	7.6	7.4	7.2

a. Last Year's Accomplishments

Department staff monitored compliance with guidelines counseling women of childbearing age and all pregnant women on the dangers of tobacco use and provided technical assistance when indicated. IMRH staff noted an increase in prenatal smoking rates in the last quarter of 2003. DOH staff wrote a grant and partnered with March of Dimes - Johnson & Johnson Pediatric Institute Grand Rounds Program. With funding from this grant, we trained over 100

public and private direct service providers during November and December of 2003 on the Make Yours a Fresh Start Family and ACOG's Smoking Cessation, A Clinician's Guide to Helping Pregnant Women Quit Smoking models. We trained over 100 additional service providers in the spring of 2004. County health departments, Healthy Start coalitions, and state health office staff monitored prenatal smoking indicators at the county level. Monitoring also occurred through data review, review of delivery plans and annual action reports, and coalition and CHD monitoring visits. Technical assistance was provided during these visits and as requested or when data indicated a need. Information on tobacco cessation and secondhand smoke was forwarded to providers through on-site training, conference calls, site visits, meetings, and email communications. IMRH staff worked with PRAMS staff on PRAMS reports. Mass media campaigns, brochures, and individual counseling were offered through the Florida Quit For Life Line, 1-(877) U CAN NOW, a toll-free help line that provides information and counseling to help people quit smoking. These activities promoted the provision of tobacco cessation services and education on reduction of secondhand smoke by direct services providers including family planning staff, prenatal care providers and home visitors. In 2004, over 4,067 pregnant women and families of 2,443 infants received tobacco cessation services and information on reducing secondhand smoke through Healthy Start. The measure was chosen because tobacco use during pregnancy has been shown to increase low birth weight deliveries. This measure relates to the priority needs of reducing low birth weight and reducing infant mortality.

Provisional data for 2004 indicate that 9.01 percent of pregnant women reported tobacco use during pregnancy as indicated on birth certificates. This is higher than our FY2004 objective of 8.2 percent. While responding to hurricanes reduced the capacity of Healthy Start and county health department staff to provide smoking cessation services, many activities continued during FY2004 include the monitoring, technical assistance, and provision of information described above. The Florida Quit For Life Line was promoted and a form for faxing referrals to the quit line was developed and promoted through the trainings and teleconferences. We modified the Alcohol, Tobacco and Other Drug draft web pages projected to go on the Department of Health website.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of guidelines directing health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use.				X
2. Monitoring of prenatal smoking indicators by county health department and state health office staff.				X
3. Training and technical assistance on the Make Yours a Fresh Start Family program and ACOG’s Smoking Cessation During Pregnancy: A Clinician’s Guide to helping Pregnant Women Quit Smoking.				X
4. Forwarding information on tobacco cessation and secondhand smoke through conference calls, site visits, meetings, and email communications.			X	
5. Monitoring of compliance with Healthy Start Standards and Guidelines standards for tobacco cessation.				X
6. Promoting partnerships with public and private sector prenatal care providers to increase access to smoking cessation services and implement programs and policies supportive of prenatal smoking				X

cessation and reduction of second hand smoke.				
7.				
8.				
9.				
10.				

b. Current Activities

Activities described for FY2004 are also being conducted in the current year. In addition, department staff formed a partnership with the Florida AHEC Network to provide 10 regional trainings on the Make Yours a Fresh Start Family program, and ACOG's Smoking Cessation During Pregnancy, and to provide two web-enhanced audio teleconferences - one on each model. The contract also includes airing radio and television public service announcements in the eight counties which have the highest rates of smoking during pregnancy. These PSAs will reach over 30 counties. IRMH staff is participating with the Division of Health Awareness and Tobacco (DHAT) to expand the reach and depth of this campaign through their CDC grant. IRMH is also working with DHAT on the Florida Tobacco Strategic Plan and IRMH staff are active partners on the Florida Prevention Advisory Council. The Alcohol, Tobacco and Other Drug web pages are on the department's development server. We expect the web pages to be on the Department of Health website by October. The site will include web pages on tobacco cessation and reducing exposure to secondhand smoke.

c. Plan for the Coming Year

During FY2006, we will continue the activities listed above. We will continue to provide technical assistance and support training opportunities on both Make Yours a Fresh Start Family and ACOG's Smoking Cessation, A Clinician's Guide to Helping Pregnant Women Quit Smoking. A Florida study indicated work is needed to bolster tobacco cessation once the baby arrives. Staff will work on strategies to improve continuation of tobacco cessation after birth including promoting Moffett Cancer Center's Kick It campaign. We will continue to monitor smoking cessation activities statewide, continue to evaluate data showing the success of these activities and data on smoking rates in general, and provide technical assistance as indicated. We will also continue to maintain a list of tobacco cessation contacts for each county health department and Healthy Start coalition and provide the contacts with updates on tobacco cessation activities and resources. MCH staff will work with the department's Division of Health Awareness and Tobacco on implementing the Strategic Plan, and to develop new initiatives for reaching women who have not responded to current initiatives. We hope to continue working with the AHEC Network and the Governor's Office of Drug Control Policy expanding the reach of the prenatal tobacco cessation media campaign.

State Performance Measure 6: *The rate per 100,000 of reported cases of perinatal transmission of HIV*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	16	15.5	15	10.2	10

Annual Indicator	8.3	15.9	12.3	6.3	6.2
Numerator	33	62	50	26	26
Denominator	398369	389451	407611	413130	417318
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9.8	9.6	9.4	9.2	9

Notes - 2003

Data for 2003 are not yet available.

a. Last Year's Accomplishments

The collaboration of numerous agencies has contributed to lowering the rate of perinatal HIV transmission. The Department of Health, Bureau of HIV/AIDS, continued to contract with community-based organizations to conduct outreach to pregnant women at risk for delivering an HIV-infected or substance-exposed infant, and link them with needed services such as prenatal care. The Targeted Outreach for Pregnant Women Act (TOPWA) program currently serves 12 Florida counties. In addition, the bureau targets health care providers with education, training, and technical assistance on Florida's HIV testing laws and the latest recommendations for the treatment of HIV-infected pregnant women, through a contract with the Florida/Caribbean AIDS Education and Training Center. In 2004, the AETC, the Bureau of HIV/AIDS, the National Pediatric HIV Resource Center and the Centers for Disease Control and Prevention, conducted two-day training for Florida and Caribbean hospitals on implementing rapid HIV testing at labor and delivery. The AETC is providing ongoing technical assistance and working with additional hospitals to implement rapid testing for women of unknown HIV status.

The University of Florida released two reports based on studies commissioned by the Department of Health, Bureau of HIV/AIDS, to assess obstetric provider HIV testing and treatment practices, and policies and procedures related to HIV testing and treatment in Florida hospitals. Study results are being used to direct provider training and education projects by the AETC.

The department's Infant, Maternal, and Reproductive Health Unit also collaborated with the Bureau of HIV/AIDS to assist with revision of technical assistance guidelines and to promote the offering of universal HIV testing to all pregnant women at their first prenatal visit and again at 28-32 weeks gestation. The Healthy Start coalitions have been charged with encouraging women to access early prenatal care.

In April 2004, a statewide meeting was convened for coordinators of the 2002/2003 Regional Perinatal Community Integration Meetings to share best practices and discuss ongoing issues. As a result of the integration meetings, many communities in Florida have actively improved their outreach/education activities and are more aware of barriers to accessing care issues.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participating in a Statewide Perinatal Integration Meeting for				

coordinators of the 2002 community meetings, to share best practices and discuss ongoing barriers to care for pregnant women.			X	
2. Collaboration with the Targeted Outreach for Pregnant Women Act (TOPWA) Program.				X
3. Participation in a Bureau of HIV/AIDS work group to implement recommendations on further reducing perinatal HIV transmission based on the CDC's 2003 HIV/AIDS initiative.				X
4. Working with other state agencies to strengthen policies and procedures relating to perinatal HIV prevention and the development of appropriate operating guidelines.				
5. Revised MCH HIV/AIDS technical assistance guidelines to incorporate the latest policies pertaining to the HIV testing of pregnant women and treatment guidelines.				X
6. Collaboration with the STD program on follow-up of pregnant women testing positive for HIV.			X	
7. Continued work with the department's MCH HIV Prenatal Screening Offer workgroup.				X
8.				
9.				
10.				

b. Current Activities

In April 2003, the CDC unveiled a new initiative to strengthen HIV prevention in the United States. This initiative, Advancing HIV Prevention: New Strategies for Changing Epidemic, includes four key strategies: Making voluntary HIV testing a routine part of medical care, implementing new models for diagnosing HIV infections outside medical settings, preventing new infections by working with persons diagnosed with HIV and their partners, and further decreasing perinatal HIV transmission.

The Florida Department of Health, Bureau of HIV/AIDS has developed four workgroups to address each of the four key strategies. The team members represent organizations and agencies throughout the state. The perinatal workgroup (Team 4) convened in January 2004 to develop action steps towards meeting the goals of the Advancing HIV Prevention initiative and address areas of concern raised at the community integration meetings. By November 2004, many of these goals had been met. A report may be accessed at http://www.doh.state.fl.us/disease_ctrl/aids/AHP/AHPmins.html

The Infant, Maternal, and Reproductive Health Unit continues to track and emphasize the requirement to offer HIV testing to all pregnant women accessing care at the CHD at their initial visit and again at 28-32 weeks. In 2005, the Florida Legislature passed a bill that now makes HIV testing part of the routine panel of tests offered to pregnant women with the option to refuse testing. The Healthy Start coalitions are continuing to educate and increase awareness in the communities concerning the need for women to access prenatal care early in their pregnancy.

TOPWA Programs are continuing their outreach and care coordination efforts. They have expanded their programs into the correctional settings; TOPWA agencies in Miami-Dade, Orange and Hillsborough counties provide services in their local county jail and other TOPWA providers are linked with their jails to receive client referrals upon release. Provider training and community education will continue to be provided through contract with the Florida/Caribbean AETC.

c. Plan for the Coming Year

In FY 2006, we will continue the various collaborative education/outreach projects. An ongoing focus will be on implementing rapid HIV testing in labor and delivery settings and increased provider awareness of the state requirement to offer HIV testing at the initial prenatal visit and again at 28-32 weeks.

State Performance Measure 7: *The rate per 1,000 of hospital discharges due to asthma in children age 0-14*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	2.8	2.6	3	2.8	2.6
Annual Indicator	3.0	3.1	2.9	3.2	2.9
Numerator	9171	9848	8924	10263	9393
Denominator	3100981	3128539	3100918	3188880	3213214
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.5	2.4	2.3	2.2	2.1

Notes - 2002

Data for 2002 are not available. We get hospital discharge data from another agency (AHCA). Because of the large number of hospitals and delays in reporting, data for this indicator is a year behind. We expect data for 2002 next year.

a. Last Year's Accomplishments

Activities to reduce childhood asthma discharges included education, prevention, and asthma management activities provided by county health departments and their school health programs. These activities help to reduce asthma hospitalizations and rehospitalizations of children. Training and education improve the early identification of high-risk children and assist in establishing a medical home for children with asthma. The department, its county health departments, and community partners provided technical assistance, asthma resources, information on Web links, health education training materials, and patient brochures. School Health Services provided school-based preventative and primary care services to students with asthma. Partnerships to address asthma reduction and asthma control were developed with Environmental Health, School Health Services, the Environmental Protection Agency, and the CDC.

County health department outreach, case management, and education assisted parents with child health insurance activities which enabled more children to access preventive and primary care. Education of children and their families about asthma and asthma self-management continued to be an important initiative. Populations served included infants, children, and

children with special health care needs. Increased identification of students with asthma resulted in an increase in the documented rate of school students with asthma from 49.8 per 1,000 for FY2003 to 55.3 per 1,000 for FY2004. The School Health Services program provided care management, including medication administration, child self-care education, and prevention. School-based asthma education initiatives utilized curricula such as Open Airways from the American Lung Association and Tools for Schools from the CDC. Infrastructure-building services included supporting education and prevention initiatives through the provision of expertise, technical assistance, and guidance in childhood asthma management and care, and provision of asthma resources to community health care providers, schools, day care facilities, children, and families.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Asthma education and prevention efforts through Healthy Start coalitions and CHDs school health programs to reduce asthma hospitalizations and rehospitalizations for children.	X			
2. Training and educational initiatives to improve the early identification of high-risk young children with asthma and assist in establishing a medical home for children with asthma.		X		
3. Provision of technical assistance and supportive asthma resources and training materials to Healthy Start coalitions and CHDs.			X	
4. Provision of childhood asthma educational web links, health education training materials and patient brochures and posters to Healthy Start coalitions, CHDs, and community partners.			X	
5. Development of a child health strategic plan for Florida's children to address early identification, diagnosis, and treatment of children at high risk for asthma.				X
6. Partnerships with Environmental Health, EPA, and CDC that address asthma reduction and asthma control.				X
7.				
8.				
9.				
10.				

b. Current Activities

The department collaborates with other agencies to reduce indoor and outdoor environmental factors that contribute to asthma in children. This includes the American Lung Association, the Allergy and Asthma Foundation, and other public/private agencies and organizations that raise public awareness of indoor and outdoor environmental factors that contribute to asthma in children. Policies are developed and implemented to identify, screen, diagnose, and treat childhood asthma. We continue to address lay public and health care provider education and training needs, and address indoor and outdoor air quality issues in the community. Staff serves on Community Health Advisory Boards and School Health Advisory Committees that provided input to schools, childcare agencies, Head Start programs, and community agencies to raise awareness of childhood asthma, provide asthma education resources, and promote collaborative efforts to link children, families, schools, and health care resources.

The School Health Program is currently releasing Nursing Guidelines for the Delegation of

Care for Students with Asthma in Florida Schools, which are the result of a workgroup composed of physicians, university researchers, and providers of health care services to school children. These guidelines are intended to meet the demand for guidance in the management of students with asthma in schools where there may be insufficient or no on-site health professionals, and will help to ensure that all schools have the training and resources necessary to protect the health and safety of students with asthma. Adequate asthma management in schools will contribute to a reduction of child hospital admissions due to asthma. The department will continue to partner with state and national environmental health agencies in an effort to reduce airborne pollutants in homes, schools, and workplaces. We recognize that reductions in rehospitalization are an indicator of the health care delivery system's success in helping families and children manage and control asthma. Through our child health program, we are providing childhood asthma resources for the county health departments to educate their staff, health care providers, children, and families about the disease and how asthma is affected by environmental conditions.

Four hurricanes hit the state in the fall of 2004 and their aftermaths have affected many communities and schools. The School Health Program worked with the communities on identifying environmental factors that may precipitate asthma attacks in children.

c. Plan for the Coming Year

In FY2006, we will continue to work with the county health departments and their school health programs to promote childhood asthma education and prevention activities for children and their families. We will continue to partner with Department of Health Environmental Health staff and community agencies and organizations to help improve the early identification of high-risk young children with asthma, and promote the establishment of medical homes for children with asthma. We will continue to raise public awareness and educate the public that severe asthmatic attacks can be prevented through proper treatment and monitoring of the disease.

Collaborative efforts will continue to support the provision of asthma education and asthma management education and training resources to health care providers in well and sick child clinics in the county health departments, promote educational activities and help health care providers practice up-to-date asthma care in treating children with asthma. We will partner with schools, childcare, and community agencies to further knowledge of asthma prevalence, prevention, causes, and risks. The School Health Program will continue to provide school-based asthma prevention and care management, and distribute and provide statewide training on the Nursing Guidelines for the Delegation of Care for Students with Asthma in Florida Schools. We will continue to disseminate childhood asthma educational materials to direct health care providers and work with local community partners to support asthma educational efforts targeted to health care providers, children, and families. We will also continue to partner with Environmental Health and participate on a statewide level task force to address environmental conditions such as airborne pollutants, dust mites, mold, and second hand tobacco smoke.

The School Health Program will work with the Florida Department of Education and partners on rule adoption, guidelines, and procedures for a recently enacted law permitting student self-administration of epinephrine auto-injectors while at school, on school buses and at school sponsored field trips.

State Performance Measure 8: *The percentage of low-income children who access dental care*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	15	15.5	18.2	18.7	19.2
Annual Indicator	16.5	17.7	22.2	22.7	22.5
Numerator	323834	392860	440959	464099	468140
Denominator	1962634	2219903	1982726	2047614	2079779
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	22.5	22.8	23.1	23.4	23.7

Notes - 2002

Data for 2002 are not yet available. Sealant indicator data are derived from an ad hoc report from Medicaid. The report should be available sometime in July, and we would calculate indicator data from that, probably by late July.

Notes - 2003

Data for 2003 are not yet available.

a. Last Year's Accomplishments

Increase in access to dental care for children has resulted through increased capacity over the last several years by private-sector Medicaid providers, county health departments, community health centers, dental schools, the Florida Dental Association's volunteer program Project Dentists Care, Healthy Kids, MediKids and Children's Medical Services. The slight drop in access in 2004 resulted from less access through private sector Medicaid providers, the largest provider of care. This drop was most likely due to the lack of data for a 6-month period from the state's largest county. If the number of children treated remained the same in this county as in 2003, the percent of children with access would have increased to 23.7 percent. The number of children reached by county health department dental programs increased by 10 percent over the previous year, reaching over 88,000 children. This county health department increase resulted from both increased capacity and improved performance.

Significant progress was made in the development of a state oral health improvement plan for disadvantaged persons, facilitated by a HRSA State Oral Health Collaborative Systems grant. This broad-based initiative has the potential to increase awareness of oral health issues, collaboration, and partnerships and to facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors.

Two of the largest non-fluoridating systems implemented fluoridation, increasing Florida's population on community water systems receiving the benefits of fluoridation to 74 percent. Long-term benefits will impact access through reduced treatment needs resulting in increased access through existing providers.

County health department dental program guidelines were revised and converted into a self-assessment format. These guidelines will facilitate quality improvement activities.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors.				X
2. Conduct MCH funded Emergency Referral and Preventive Dental Projects.	X		X	
3. Promote increased access through county health department safety net programs.	X			
4. Promote the integration of oral health education in WIC, Child Nutrition and other county health department programs, as appropriate.				X
5. Promote the start of oral health practices in infancy and appropriate use of fluoride products throughout early childhood in conjunction with CDC's campaign, "Brush Up on Healthy Teeth."			X	
6. Promote the development of community and school-based preventive and educational programs.			X	
7. Develop Internet site to facilitate information exchange.				X
8.				
9.				
10.				

b. Current Activities

State oral health improvement plan activities will continue. The plan will be finalized through additional public input obtained from four regional meetings and web-site comments. A website related specifically to the state plan and current initiative is under development. State forums to increase awareness of the needs of specific population groups, such as Head Start, HIV/AIDS, etc. and to development specific objectives will be conducted. County-level meetings will be conducted to increase collaboration and partnerships at the local level. The integration of oral health into all appropriate DOH programs through the development of protocols and implementation activities at the county level will receive major emphasis.

The promotion of increased capacity through county health department programs and increased quality improvement activities will continue. An application process for additional funding for county health department initiatives is in progress. Statewide assessments of county health department guidelines and records are also currently in progress.

Promotional activities to increase fluoridation will continue.

Establishment of an additional staff position to support efforts is currently in progress. This position is funded through the MCH Block Grant.

c. Plan for the Coming Year

Ongoing FY2005 activities will continue. Through the department's Reducing Oral Health Disparities initiative to support county health department infrastructure expansion, incremental progress will continue to expand access to low-income and minority populations. The program will continue to advocate for an outcome-based surveillance system that is vitally needed to increase public awareness and to monitor the impact of activities on the improvement in oral health status.

State Performance Measure 9: *The percentage of pregnant women screened by Healthy Start*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	55	57	59	52	54
Annual Indicator	57.5	49.1	49.5	51.2	60.1
Numerator	117223	100473	101190	108218	130581
Denominator	203743	204685	204483	211203	217131
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	62	63	64	65	66

a. Last Year's Accomplishments

During FY2004, 60.1 percent of pregnant women were screened by Healthy Start, a significant increase over the 51.2 percent screened in FY2003. This indicates more women are being informed about the process and encouraged to consent to screening. Florida statutes require providers to offer Healthy Start prenatal risk screening to all pregnant women. The screen identifies environmental, social, psychosocial, and medical risk factors that make a woman more likely to experience preterm delivery or delivery of a low birth weight baby.

The department provided technical assistance to Healthy Start coalitions, helping them identify and confront issues that may impact the screening rate. Many coalitions developed and implemented strategies to increase prenatal screening rates, provided ongoing technical assistance to communities, and coordinated with the Healthy Families Florida program to reduce duplication of services.

To enhance the screening form, the department implemented revisions in March 2004, which included softening the consent statements, adding the department and Healthy Start program logos, and adding governing authority statements. The department held four regional Healthy Start Core Programmatic training sessions during June and July 2004, and also initiated quarterly core programmatic training conference call sessions in October 2004.

The department subcontracted with the coalitions to conduct consumer and provider focus groups regarding prenatal and infant screening forms, screening procedures, and the Healthy Start program. The department also disseminated an electronic survey to community liaisons, care coordinators, and coalition executive directors, to obtain feedback on screening processes, perceived barriers to screening, and the development of strategies to increase screening rates.

The department continued to generate the Healthy Start Coalition Progress Report, worked with the coalitions to identify and implement new strategies for improving the prenatal screening rates, facilitated conference calls with community liaisons, and marketed the program through brochures in English, Spanish, and Creole.

Local county health departments continued to utilize the prenatal screening module to enter data locally, increasing the timeliness of information in data reports. There are ongoing quality improvement activities for data accuracy, completeness, and timeliness that are critical to ensuring the validity of this measure.

Strategies to increase screening rates are shared between the department, Healthy Start coalitions, and local health departments through conference calls and face-to-face meetings. The Healthy Start Screening Central Workgroup and the Screening Strategy Workgroup continue to monitor the effectiveness of the screening instrument. Healthy Start coalition contracts include a core outcome measures on the Healthy Start screening consent rate and the Healthy Start screening rate.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Start prenatal screening outreach will continue to provide training and technical assistance for all prenatal healthcare providers.				X
2. Strategies to increase screening rates are elicited from county health departments and coalitions on the monthly Healthy Start meet-me-call.				X
3. Promotion of Healthy Start screening as beneficial for all pregnant women.			X	
4. Healthy Start Screening Central Workgroup meetings to discuss annual analysis of Infant screening instrument and strategies for addressing trends of screening data.				X
5. Continuation of a joint Screening Strategy workgroup (DOH & Coalitions) to assess current strategies used by coalitions and make recommendations to the association for possible statewide implementation.			X	
6. The percentage of pregnant women screened by Healthy Start is specified as a core outcome measure in the Healthy Start coalition contracts as of July 1, 2002.			X	
7. Conduct annual QA/QI monitoring of Healthy Start coalitions and county health departments, which includes review and discussion of percentage of women screened by Healthy Start.				X
8.				
9.				
10.				

b. Current Activities

The department's Infant Maternal and Reproductive Health unit is in the process of revising the 1996 version of the Healthy Start prenatal and infant risk screening brochures and will also be revising the Healthy Start Screening chapter in the Healthy Start Standards and Guidelines this year. With dissemination of the revised brochures, a uniform message regarding the importance of prenatal screening will help raise awareness of health care providers, pregnant

women, women of childbearing age, and their families. Community liaisons continue to provide Healthy Start prenatal screening outreach, training, and technical assistance to providers and the community.

Additional activities include developing an online marketing resource toolkit in collaboration with the Healthy Start coalitions; activities to increase community knowledge, understanding and utilization of screening data; and identification of new partners to assist in the promotion of screening. The department will continue to provide quarterly conference call trainings on screening as appropriate.

The department continues to collaborate with the coalitions and Healthy Families Florida to identify innovative strategies to promote the importance of Healthy Start screening and the Healthy Start program through monthly and quarterly meetings. The department holds bimonthly conference calls with the community liaisons for information sharing regarding outreach and education to prenatal health care providers on the benefits of the Healthy Start program and the importance of offering each patient the risk screen in a manner that encourages consent. The department also continues to facilitate the Healthy Start Central Screening Workgroup and Healthy Start Screening Strategy Workgroup, to assess current strategies and make recommendations for possible statewide implementation.

The Healthy Start Screening Central Workgroup continues to meet to share updates on the Healthy Start prenatal screening instrument, related data and research, and strategies for addressing trends of screening data. The Healthy Start Screening Advisory Committee will be reconvened this year and is responsible for examining the possibility of changing the screening criteria to improve risk screen performance. In order to prepare for the Statewide Screening Advisory Group meeting, evaluation staff members are gathering data to analyze the Healthy Families Florida questions that were added, to see if risk factors for child abuse are also risk factors for low birth weight and prematurity. Healthy Start coalition contracts include this measure as a core outcome measure. The department continues to provide ad hoc data reports to the coalitions for trend analysis.

c. Plan for the Coming Year

In FY2006, we will continue to develop and implement screening marketing materials based on data obtained via focus groups and surveys completed by coalitions with the community members and community liaisons/coalition staff, respectively. The department will continue to hold bimonthly conference calls with community liaisons for information sharing and problem solving, develop ad hoc reports for local use, and solicit additional partners to assist in the promotion of Healthy Start risk screening.

In FY2006, a uniform message regarding prenatal screening will continue to be disseminated throughout the state to raise the awareness of health care providers, pregnant women, women of childbearing age, and their families of the importance of this screen. Data will be collected to measure the scope and effect of marketing materials, provider, and consumer education provided. Consumer education information and standard professional development information will be provided to local Healthy Start coalitions, county health departments, and other community partners. This effort will be funded, in part, through a contract between the Agency for Health Care Administration and the department.

The department will also continue to evaluate the Healthy Start prenatal screening instrument annually to ensure that the instrument is valid and reliable, and that it maintains a proportional sensitivity to the original screen.

The Healthy Start Strategy Workgroup will continue to meet, review strategies, and identify recommendations for statewide implementation. New strategies that are proven effective will be

shared on the monthly Healthy Start Meet Me Calls with care coordinators and coalitions. Healthy Start coalition contracts will continue to include a core outcome measure on the Healthy Start screening consent rate in addition to the Healthy Start screening rate.

State Performance Measure 10: *The percentage of infants screened by Healthy Start*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	76	77	78	74	76
Annual Indicator	75.0	71.2	72.3	70.9	69.6
Numerator	152880	145827	147942	149644	151186
Denominator	203743	204685	204483	211203	217131
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77	78	79	80	81

a. Last Year's Accomplishments

During FY2004, 69.6 percent of all infants were screened by Healthy Start, which did not meet our objective of 74 percent. Florida's Healthy Start initiative provides for universal screening for infants. This performance measure is used as an indicator for ensuring all families of infants are offered the Healthy Start infant risk screening as required by Florida statutes. The screen identifies environmental, social, psychosocial, and medical risk factors that make an infant more likely to experience death in the postneonatal period.

Healthy Start coalitions explored possible causes for the decline in the infant screening rates, while the Department of Health provided technical assistance as needed based on screening trends. Some Healthy Start coalitions developed and implemented innovative strategies in an effort to increase infant screening rates.

To enhance the screening form, the department implemented revisions in March 2004, which included softening the consent statements, adding the department and Healthy Start program logos, and adding governing authority statements. The department held four regional Healthy Start Core Programmatic training sessions during June and July 2004, and also initiated quarterly core programmatic training conference call sessions in October 2004.

The department subcontracted with the coalitions to conduct consumer and provider focus groups regarding prenatal and infant screening forms, screening procedures, and the Healthy Start program. The department also disseminated an electronic survey to community liaisons, care coordinators, and coalition executive directors, to obtain feedback on screening processes, perceived barriers to screening, and the development of strategies to increase screening rates.

The department continued dissemination of the Healthy Start Coalition Progress Report, worked with the Healthy Start coalitions to identify and implement new strategies for improving the infant screening rate, facilitated conference calls with the Healthy Start coalition community liaisons and marketed the Healthy Start program through brochures that are available in English, Spanish, and Creole.

Strategies to increase infant screening rates are shared between the Florida Department of Health, Healthy Start coalitions, and local county health departments on conference calls and in face-to-face meetings. Many coalitions have developed public awareness materials to promote Healthy Start screening as beneficial for all infants. Infrastructure-building services include planning and evaluation of the Healthy Start Screening instrument and its effectiveness by the members of the Healthy Start Screening Central Workgroup and the Screening Strategy Workgroup.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Start infant screening outreach to provide training and technical assistance for birthing facilities.				X
2. Strategies to increase screening rates are elicited from county health departments and coalitions on the monthly Healthy Start meet-me-call.				X
3. Promotion of Healthy Start screening as beneficial for all newborn infants.			X	
4. Healthy Start Screening Central Workgroup meetings to discuss annual analysis of infant risk screening instrument and strategies for addressing trends of screening data.			X	
5. Continuation of the screening strategy workgroup, which was established to assess current strategies used by coalitions and make recommendations to the association for possible statewide implementation.				X
6. Conduct annual QA/QI monitoring of Healthy Start coalitions and county health departments, which includes review and discussion of percentage of women screened by Healthy Start.				X
7.				
8.				
9.				
10.				

b. Current Activities

The department's Infant Maternal and Reproductive Health unit is in the process of revising the 1996 version of the Healthy Start Infant Risk Screening brochure and will also be revising the Healthy Start Screening Chapter 3 in the Healthy Start Standards and Guidelines this year. With the dissemination of the revised brochures, a uniform message regarding the important of infant screening will help to raise the awareness of Florida's mothers and their families. Healthy Start coalition staff continues to provide Healthy Start infant screening outreach, training and technical assistance to birthing facilities. Additional activities include development of an online marketing resource toolkit with downloadable documents in collaboration with the Healthy Start coalitions, continuance of activities to increase community knowledge, understanding and

utilization of screening data through ongoing analysis and continuance of identification/solicitation of new partners to assist in the promotion of screening. The department will continue to provide quarterly Healthy Start screening core programmatic conference call trainings on screening on a quarterly basis, as appropriate.

We continue to collaborate with the Healthy Start coalitions and Healthy Families Florida to identify innovative strategies to promote the importance of Healthy Start screening and the Healthy Start program through monthly and quarterly meetings. Coalitions employ community liaisons who provide Healthy Start prenatal screening outreach, training, and technical assistance to birthing facilities about the screening instrument. The department continues to hold bimonthly conference calls with the community liaisons for information sharing regarding providing outreach and education to birthing facility staff regarding the benefits of the Healthy Start program as it relates to their patients and the importance of offering the parent of each infant the risk screen in a manner that encourages consent. The department also continues to facilitate the Healthy Start Central Screening Workgroup and Healthy Start Screening Strategy Workgroup for the purpose of assessing current strategies used by all coalitions and making recommendations for possible statewide implementation and the monthly Healthy Start Meet Me Call, which provides an avenue of discussion for ideas and concerns about Healthy Start screening and the Healthy Start program.

The Healthy Start Screening Central Workgroup continues to meet to share updates on the Healthy Start infant risk screen, related data and research and discussion of strategies for addressing trends of screening data. Healthy Start coalition contracts include this measure as a core outcome measure. The department continues to provide ad hoc data reports to the coalitions for trend analysis.

c. Plan for the Coming Year

In FY2006, we will continue to implement screening marketing materials developed from data obtained via focus groups and surveys completed by coalitions with the community members and community liaisons/coalition staff, respectively. The department will continue to hold bimonthly conference calls with community liaisons for information sharing and problem solving, develop ad hoc reports for local use, and solicit additional partners to assist in the promotion of Healthy Start risk screening.

The department will also continue to evaluate the Healthy Start infant risk screen annually to ensure that the instrument is valid and reliable, and that it maintains a proportional sensitivity to the original screen. The department has plans to reconvene the Statewide Screening Advisory group for considering revisions to the infant risk screen as soon as analysis is available to suggest improvement to the instrument. It is anticipated that this will occur in 2006. In order to prepare for the Statewide Screening Advisory Group meeting, Infant, Maternal and Reproductive Health evaluation staff members are allowing time to gather data post implementation of the revised birth certificate implemented March 2004, which is the source of data for the infant risk screen.

The Healthy Start Strategy Workgroup will continue to meet, review strategies, and identify recommendations for statewide implementation. New strategies that are proven effective will be shared on the monthly Healthy Start Meet Me Calls with care coordinators and coalitions. Healthy Start coalition contracts will continue to include a core outcome measure on the Healthy Start screening consent rate in addition to the Healthy Start screening rate.

E. OTHER PROGRAM ACTIVITIES

Childhood Lead Poisoning Prevention Initiative: A DOH environmental health program that works with

county health departments to enhance their data collection and case management capabilities for following and treating children with elevated blood lead levels.

Comprehensive Child Health Services: Child health services are provided to children age birth to 21 in most of the 67 county health departments in Florida. Counties may also contract services to private providers or other agencies. Comprehensive child health services are designed to integrate preventive health services and health promotion while minimizing cultural, geographic and financial barriers to care.

Early Childhood Comprehensive Systems (ECCS) Project: The project supports state MCH agencies and their partner organizations to strengthen the early childhood system of services for young children and their families. Focus areas include: access to medical homes, social-emotional development and mental health, parent education, early care and education services, and family support services.

Family Health Line: A toll-free hotline that promotes the importance of early and continuous prenatal and infant care. The hotline provides basic information on pregnancy and how to access prenatal care, infant care, family planning, WIC, drug abuse treatment, and other pregnancy-related services. The hotline also arranges referrals to private, public, and volunteer health promotion groups. During 2004, there were 20,981 incoming calls to the Family Health Line, a significant increase compared to the 14,439 calls made in 2003.

Family Planning Waiver: The waiver extends eligibility for family planning services from 60 days to 24 months for all women in Florida with incomes at or below 185 percent of the poverty level who received a pregnancy related service paid for by Medicaid. In November 2003, the waiver was renewed for a three year period.

Fetal and Infant Mortality Review: An information-gathering process designed to identify deficiencies in the maternal and infant health care system. Through individual case review, local FIMR projects attempt to identify factors that may contribute to fetal and infant death.

Florida Folic Acid Council: The Florida Folic Acid Council (FFAC) was created in 1999 to ensure that women in Florida and their health care providers are aware of the benefits of folic acid in decreasing the risk of birth defects of the brain and spine usually referred to as neural tube defects. Comprised of public and private partners throughout the state, the group supports a wide range of educational activities that have contributed to documented increases in what health care providers and women of childbearing age know about folic acid.

Osteoporosis Prevention and Education Program: Provides information and increases awareness of the benefits of physical activity, healthy eating habits, and to not smoke and drink alcohol in order to build and maintain healthy bones.

Pregnancy Associated Mortality Review: A population-based surveillance and selective case review process aimed at reducing maternal mortality in Florida. The PAMR project monitors trends in pregnancy-associated deaths, and identifies gaps in care, service delivery problems, and areas in which communities can facilitate improvements in the service delivery system for women.

Pregnancy Risk Assessment Monitoring System: The PRAMS project conducts population-based surveillance of selected maternal behaviors that occur during pregnancy and early infancy, in 35 states and the District of Columbia.

Reach Out and Read: An early literacy program that involves pediatricians and nurses supporting children's language and literacy development through various interventions. During well-child visits, children under 5 receive developmentally appropriate books to take home, volunteers read to the children in the waiting room, and doctors and nurses follow up with parents to stress the importance of reading aloud to their children.

Responsible Fatherhood Project: This project encourages fathers of children (age birth to 5) to become better fathers by making available resources, support, information and education to enhance responsible fatherhood behavior, positive relationships with children, and shared parenting relationships with the children's mothers. The project also seeks to increase awareness in the local community of the importance of fathers being actively involved with the care of their children.

Sexual Violence Prevention Program: Program staff provides training and technical assistance to county health departments and rape crisis centers, develops program and policy guidelines, responds to legislative issues, provides professional and public education, and conducts a public awareness campaigns on rape risk reduction and on the prevention of rape.

Staff Development, Education and Training: MCH staff develops training materials targeted towards MCH providers. They provide ongoing training and technical assistance to increase skills needed to screen, assess, identify needs, coordinate and provide services.

Statewide Birth Defects Surveillance System: A system designed to reduce the impact of birth defects, investigate possible causative agents, disseminate information, and plan and evaluate the effects of interventions.

Sudden Infant Death Syndrome: The Department of Health oversees the professional support activities offered to people affected by SIDS. Activities focus on increasing the awareness of SIDS and providing the latest prevention information to health providers and trainers of secondary caregivers, such as childcare providers.

Voluntary Pre-Kindergarten: A program designed to prepare 4-year-olds for kindergarten and build the foundation for their educational success. The program allows a parent to enroll his or her eligible child (four years old by September 1 and residing in Florida) in a free VPK program.

F. TECHNICAL ASSISTANCE

Florida is not seeking technical assistance at this time.

V. BUDGET NARRATIVE

A. EXPENDITURES

There were no significant variations in expenditures in forms 3, 4, and 5 from previous years. On Form 3 Line 8 for budgeted other federal funds, we underestimated our other federal funds for 2004 and 2005 when we did Form 2 in previous years. That left us with an incorrect amount on Form 3 Line 8 for other federal funds budgeted for 2004. The actual award amounts for other federal funds for 2004 was $424,797,348; the form has now been updated. Expenditure data for Florida is included on forms 3, 4, and 5.

B. BUDGET

Federal funding through the Title V MCH Block Grant provides needed support to our statewide efforts. Of the $20,818,016 budgeted as the expected federal allotment for 2006, $7,101,025 is budgeted for preventive and primary care for children (34.11 percent), $8,491,669 for children with special health care needs (40.79 percent) which meets the 30 percent-30 percent requirements. In addition, $1,819,495 (8.74 percent) is budgeted towards Title V administrative costs, less than the maximum of 10 percent requirement. Total state match for 2005 is $347,141,144, which greatly exceeds the state's FY 1989 maintenance of effort amount of $155,212,322. The sources of state matching funds include $315,396,057 from state general revenue and the CMS Donations Trust Fund and $31,745,087 from the Federal Grants Trust Fund and the Social Services Block Grant Trust Fund. Sources of other federal funds include the SSDI grant, the Abstinence Education Block Grant, WIC, the USDA CACFP grant, the Preventive Health Services Block Grant, Florida's Medipass Waiver, and CDC grant awards. CDC grant awards include: tobacco, diabetes, family planning, rape prevention, cancer, cardiovascular disease, obesity, school health, and Temporary Assistance for Needy Families (TANF) funding. A complete list of other federal funds with funding amounts is included on Form 2 and in notes for that form. Budget numbers for Florida are included on forms 2, 3, 4, and 5.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.